UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

11 CIV. 2604

LEVAR T. HENRY,

Plaintiff,

-against-

SECURITY CAPTAIN MICHEAL WILLIAMS, Shield No.820; CAPTAIN GAMBLE, Shield No.88; C.O. LAMAR, Shield No. 18472; C.O. MOHR, Shield No.17362; C.O. LEOCARDIO ARIAS, Shield No. 17955; ACTING WARDEN CARLTON NEWTON; CAPTAIN CRUZ; CAPTAIN MERCEL, Shield No.381; CAPTAIN KELLY; DEPUTY WARDEN ELISEO PEREZ, JR.; CAPTAIN SHERMA DUNBAR, Shield No.717; C.O. CAMPBELL, Shield No. 18645; CAPTAIN BANKS, Shield No.819; C.O. JOHNSON, Shield No.8461; C.O. MCKELLER, Shield No. 10049; C.O. DAVIS, Shield No.15633; and THE CITY OF NEW YORK,

Defendants.

COMPLAINT
UNDER THE
CIVIL RIGHTS ACT,
42 U.S.C. §1983

JURY TRIAL DEMAND

Plaintiff, Levar T. Henry, complaining of defendants herein, respectfully alleges as follows:

JURISDICTION

1. This is a civil action, seeking compensatory damages, punitive damages and attorney's fees.

2. This action is brought pursuant to 42 U.S.C. §§1983 and 1988 and the fourteenth amendment to the Constitution of the United States.

3. Jurisdiction is founded upon 28 U.S.C. §§1331, 1343 and 1367.

4. Plaintiff, invoking the pendent jurisdiction of this court, also seeks monetary damages, both comensatory and punitive, as well as for battery and due process.

VENUE

5. Venue is properly alleged in the Southern District of New York in that the acts complained of herein occurred within this District.

JURY TRIAL DEMAND

6. Plaintiff hereby demands a trial by jury of all issues in this action that are so triable.

PARTIES

7. At all times relevant hereto, plaintiff, Levar T. Henry, was and is a natural person, resident in the County of New York and State of New York.

8. At all times relevant hereto, defendant SECURITY CAPTAIN MICHEAL WILLIAMS, Shield No.820 (hereinafter "WILLIAMS") was and is a natural person, employed by the Correction Department of defendant CITY OF NEW YORK.

9. At all times relevant hereto, defendant CAPTAIN GAMBLE, Shield No.88 (hereinafter "GAMBLE") was and is a natural person, employed by defendant CITY OF NEW YORK.

10. At all relevant times hereto, defendant C.O. LAMAR, Shield No. 18472 (hereinafter "LAMAR") was and is a natural person, employed by defendant CITY OF NEW YORK.

11. At all times relevant hereto, defendant C.O. MOHR, Shield No. 17362 (hereinafter "MOHR") was and is a natural person, employed by defendant CITY OF NEW YORK.

12. At all times relevant hereto, defendant C.O. LEOCARDIO ARIAS, Shield No.17955 (hereinafter "ARIAS") was and is a natural person, employed by defendant CITY OF NEW YORK.

13. At all times relevant hereto, defendant ACTING WARDEN CARLTON NEWTON (hereinafter "NEWTON") was and is a natural person, employed by defendant CITY OF NEW YORK.

14. At all times relevant hereto, defendant CAPTAIN CRUZ (hereinafter "CRUZ") was and is a natural person, employed by defendant CITY OF NEW YORK.

15. At all times relevant hereto, defendant CAPTAIN MERCEL, Shield No.381 (hereinafter "MERCEL") was and is a natural person, employed by defendant CITY OF NEW YORK.

16. At all times relevant hereto, defendant CAPTAIN KELLY (hereinafter "KELLY") was and is a natural person, employed by defendant CITY OF NEW YORK.

17. At all times relevant hereto, defendant DEPUTY WARDEN ELISEO PEREZ, JR. (hereinafter "PEREZ") was and is a natural person, employed by defendant CITY OF NEW YORK.

18. At all times relevant hereto, defendant CAPTAIN SHERMA DUNBAR, Shield No.717 (hereinafter "DUNBAR") was and is a natural person, employed by defendant CITY OF NEW YORK.

19. At all times relevant hereto, defendant C.O. CAMPBELL, Shield No. 18645 (hereinafter " CAMPBELL") was and is a natural person, employed by defendant CITY OF NEW YORK.

20. At all times relevant hereto, defendant CAPTAIN BANKS, Shield No.819 (hereinafter "BANKS") was and is a natural person, employed by defendant CITY OF NEW YORK.

21. At all times relevant hereto, defendant C.O. JOHNSON, Shield No.8461 (hereinafter "JOHNSON") was and is a natural person, employed by defendant CITY OF NEW YORK.

22. At all times relevant hereto, defendant C.O. MCKELLER, Shield No.10049 (hereinafter "MCKELLER") was and is a natural person, employed by defendant CITY OF NEW YORK.

23. At all times relevant hereto, defendant C.O. DAVIS, Shield No. (hereinafter "DAVIS") was and is a natural person, employed by defendant CITY OF NEW YORK.

24. At all times relevant hereto, defendant CITY OF NEW YORK was and is a municipal corporation, organized and existing pursuant to the laws of the State of New York.

45. Plaintiff still cuffed dropped to his knees. Sevarel hours later plaintiff was sent to the hospital.

46. Defendant WILLIAMS tried to make plaintiff sign a statement saying plaintiff assulted officers. Plaintiff refused to sign because he did not assult any officers.

47. Plaintiff returned from Elmhurst Hospital on or about March 13,2010 approximately 9:00 A.M. Plaintiff was not given medication prescribed by the Elmhurst Hospital doctors for pain. Plaintiff was in pain sleeping on the floor of the intake pen#6 for three (3) days without pain prescribed medication. Suary and Pope shared pen#6 with plaintiff.(EXHIBIT:D & J)

48. On or about March 15,2010, at approximately 10:25 P.M., Plaintiff was finally house in the Administrative Segregation Quad 6 Lower. On or about March 15,2010, at approximately 12:00 P.M., Plaintiff was informed by C.O. McFarlin (Mack) in the intake area (pen#6) that a message was sent to Security stating plaintiff would be killed and had to be removed from Anna M. Kross Center (AMKC).

49. On or about March 16,2010, at approximately 7:00 A.M., Plaintiff filed a Grievance at the Anna M. Kross Center law library. The form was notarized and dropped by plaintiff at the "T" Grievance Box. No investigation was done. Plaintiff got no response from AMKC Grievance Coordinator or defendant NEWTON. (EXHIBIT:E)

50. On or about March 16,2010, at approximately 9:00 A.M., plaintiff was escorted by defendant CRUZ, WILIAMS and multiple correctional officers via van to the George R. Vierno Center, a Rikers Island facility also known as MHAUII/ Punitive Segregation

Unit. Plaintiff was placed in this punitive housing area under Pre-Housing Detention status (PHD). However, plaintiff is later informed that he is being held in MHAUII/CPSU for a fight on March 13,2010, which held the penalty of eight (8) days in confinement. Defendant MERCEL advised plaintiff. Plaintiff was in Elmhurst Hospital Center and Anna M. Kross Center (AMKC) intake pen#6 on March 13,2010. As a result of false and maliciously accused by defendants plaintiff was put in the box. (EXHIBIT:F)

51. On or about March 17,2010, at approximately 7:00 A.M., defendant JOHNSON cuffed plaintiff to the back on a caged transportation bus to Bronx Hall of Justice. Plaintiff informed defendant JOHNSON of the injuries. The transportation bus has no seat belts to stop plaintiff from shifting in the caged seat. As a result plaintiff who by doctors orders was not suppose to be cuffed to the back when not in a vehicle or in a vehicle was badly injured. Painful noise came from plaintiff as it was impossible to keep his place with an abnormal right arm. His limbs slammed against the cage. Defendant JOHNSON told plaintiff, "Do what you got to do but Im not cuffing you to the front". Plaintiff was in pain and not suppose to be a MHAUII/CPSU prisoner. Driver C.O. Linton Shield #1329.(EXHIBIT:G)

52. On or about March 17,2010, at approximately 10:00 A.M., defendant DAVIS of Bronx Hall of Justice refused plaintiff medical treatment. Moreover, still re-cuffed plaintiff to the rear after plaintiff advised defendant DAVIS of the injuries.

53. On or about March 17,2010, at approximately 6:00 P.M., defendant MCKELLER refused to cuff plaintiff to the front. Plaintiff returned to Rikers Island in pain from the positioning of his arm and the unpadded cages. Driver C.O. Ortiz Shield #15388.

54. On or about March 17,2010, at approximately 8:00 P.M.,

25. The individual defendants are sued in their individual capacities as well as in their capacities as employees of defendant CITY OF NEW YORK.

26. On or about April 16,2010, at approximately 1:38 P.M., this date being within ninety (90) days after the pendent state claim herein sued upon accrued, plaintiff served upon the Comptroller of the City of New York a verified notice of claim setting forth the time, place, nature, and manner in which said claim arose.(Claim No.2010P016336).

27. On or about May 29,2010, ths date being within ninety (90) days after the pendent state claim herein sued upon accrued, plaintiff served upon the Comptroller of the City of New York a verified written notice of claim setting forth the time, place, nature and manner in which said claim arose (Claim No.2010PI02110 7 and Claim No.2010PI021108).

28. More than thirty (30) days have elapsed since the aforesaid verified notice(s) of claim(s) was served and the Comptroller has neglected and refused to make payment of said claim(s).

29. This action is commenced within one year and ninety days from the date the pendent claim herein accrued. (EXHIBIT:A)

AS AND FOR A FIRST CAUSE OF ACTION
AGAINST THE INDIVIDUAL DEFENDANTS

30. Plaintiff repeats, reiterates, and realleges each and every allegation contained in paragraphs "1" through "29" hereinabove as if more fully set forth at length herein.

31. On or about March 12,2010, at approximately 5:55 P.M., plaintiff was an inmate incarcerated in the designated as Quad 10 Lower in Anna M. Kross Center, which is located on Rikers Island in the County of Bronx, City and State of New York, with a post office address of 18-18 Hazen Street, East Elmhurst, New York

11370.

32. At the aforementioned time and place, plaintiff was told to step through the B-Gate. Thinking nothing of it without delay or resistance plaintiff stepped through it (B-Gate). The B-Gate shut behind plaintiff. It was a Friday evening and plaintiff had just returned from a nightly medication run just 30-40 minutes prior. The B-Gate shut.

33. Defendants GAMBLE,LAMAR, MOHR, and ARIAS surround plaintiff. There was another officer who stood futher back named C.O. Bryant. C.O. Bryant seemed to stand clueless or ignorant.

34. At the aforementioned time and place, plaintiff was verbally assulted with spit popping from the mouth of GAMBLE, who shouted into plaintiffs face,"Pack up now orders of Captain Williams". GAMBLE gave no explaination or probable cause.

35. Plaintiff did not respond or understand GAMBLES rage. However, plaintiff has had bad history with WILLIAMS. Defendant GAMBLE, LAMAR, MOHR, and ARIAS, acting at the aformentioned directions of defendants WILLIAMS and NEWTON, were sent to harrass plaintiff. (EXHIBIT:B)

36. Plaintiff was not given an opportunity to agree, object, or resist. The B-Gate leading to plaintiffs cell location (#15) where the property to be packed was still shut. Plaintiff was trapped.

37. Defendant LAMAR, without probable cause to do so "pepper-sprayed" plaintiff in the face blinding him and began hitting plaintiff busting his lip.

38. Defendant LAMAR grabbed plaintiffs left arm while Defendant MOHR twisting plaintiffs right arm. Defendants MOHR and LAMAR violently played tug-of-war with plaintiffs limbs, LAMAR released and MOHR violently slammed plaintiff to the floor.

Defendant MOHR continued to administer a marital arts type twist on plaintiffs right arm even after plaintiff was flat on his chest. C.O. Bryant started shouting,"You breaking his arm, get off his arm--he's not resisting". C.O. Bryant observed defendants LAMAR, MOHR, GAMBLE and ARIAS administering the beating to plaintiff. The use of force was unnecessary. Plaintiff was cuffed and unconscious.

39. Plaintiff was cuffed and unconscious.

40. Defendants ARIAS, LAMAR and MOHR began to kick and stomp plaintiff in the right side of his head, back, arm and leg while plaintiff was cuffed, flat on his chest and leftside pressed along the wall.

41. Other inmates, upon information and belief, started to throw food trays, garbage, water and juice through through the B-Gate to stop the beating of plaintiff.

42. After being beaten as foresaid, plaintiff was left lying on the floor for a period of time in chemical agents and blood. Plaintiff awoke coughing and throwing up blood. A Probe Team now present was beating on other inmates inside Quad 10 Lower.

43. Plaintiff was taken to the intake shower area with other cuffed inmates Saury, Pope and Baker from Quad 10 Lower. All were badly injuried, coughing, bleeding, and crying. Plaintiff was instructed to put his face under a shower, then photo's were taken. (EXHIBIT:C)

44. Defendant WILLIAMS ran into the shower area and struck plaintiff with one right hook. Inv. Captain Shannon observed defendant WILLIAMS administer the closed fist punch to plaintiffs face. WILLIAMS, without probable cause assulted plaintiff.

defendants CAMPBELL and BANKS refused to send plaintiff to be medically treated after returning to MHAUII/CPSU. Moreover, refused to move plaintiff from the unit. Plaintiff had no infraction pending. Plaintiff phone was kept off for 4 days by defendants.(EXHIBIT:H)

55. On or about March 23,2010, plaintiff was released from MHAUII/CPSU to GRVC population (8A 23 cell).

56. On or about May 4,2010, plaintiff returned from the law library (GRVC) to 8A 23 cell. Five minutes later defendants KELLY, DUNBAR and other correctional city employees storm plaintiffs assigned cell grabbed plaintiff from the bed and violently slammed him against the rear cell wall and twisted his right arm behind his back sending plaintiff into instant shocking pain in his injured abnormal right elbow. Plaintiff was then violently slapped 6-7 times by defendant DUNBAR. Defendant KELLY cuffed plaintiff to the back. Defendant KELLY did not want to see plaintiffs Doctors note regarding cuffing plaintiff to the back not to be done.

57. On or about May 4,2010, at approximately 7:00 P.M., plaintiff was put into MHAUII/CPSU (11A) for eight (8) more days. Plaintiff did not owe these bing days to NYDC. Defendants KELLY and DUNBAR, acting at the aforementioned directions of defendant PEREZ. Plaintiff was not allowed to use the phone until May 11, 2010. (EXHIBIT:I)

58. Plaintiff never received an infraction or displinary hearing. Plaintiff was falsely and maliciously accused of owing MHAUII/CPSU (Bing) days. G.R.V.C. Grivance Staff never responded.

59. On or about December 1,2008 - September 23,2010 plaintiff was made to wear cheap flat temporary walking shoes with no arch support for long periods of time. Defendant CITY OF NEW

YORK issued foot wear that caused fungus to plaintiffs feet. It would take Defendant CITY OF NEW YORK trained employees $6\frac{1}{2}$ to 8 months to replace worn out badly torn foot wear (shoes). The heel produced a gray rubber that floats around inside of the shoe when plaintiff was made to wear them for long periods of time. Moreover, the size plaintiff wears were never in stock. The plaintiff wears a size $8\frac{1}{2}$, but he would be given a size 7 or size 12 shoe. Defendant CITY OF NEW YORK employees felt it was perfectly normal for plaintiff to wear CITY OF NEW YORK issued foot wear four (4) sizes to big or some he had to squeeze his foot in with his heel and socks on the ground floor. Plaintiff was even given already worn foot wear that had funk from the next inmate. Plaintiff grieved multiple times and went to doctors multiple times about pain and fungus to his feet. (EXHIBIT:J)

60. The individual defendants violated plaintiffs right to the due process of law guaranteed to him by the fourteenth amendment to the Constitution of the United States in that, acting under color of state law, they, without any cause or provocation whatsoever, brutally and severely beat and humiliated him, falsely accused and not accusing him of instigating an altercation and improperly investigating death threats, improperly unfairly and unjustly disciplined him.

61. Because of the aforesaid acts committed by the individual defendants of 18-18 Hazen St. and 09-09 Hazen St. (East Elmhurst, New York 11370),and Transit Department (NYCTD), and Bronx Hall of Justice, plaintiff suffered a deprivation of the right to the due process of law guaranteed to him by the fourteenth amendment to the Constitution of the United States and, as a

result, suffered, and continues to suffer, serious and permanent physical and emotional injuries, has required and continue to require medical treatment for his injuries and was placed in solitary confinement for nothing.

62. By reason of the aforementioned unconstitutional and illegal actions taken against him by the individual defendants, plaintiff has been damaged in the amount of Five Hundred Thousand ($500,000) Dollars and demands an additional Two Hundred Sixty Thousand ($260,000) Dollars as punitive damages against the individual defendants.

AS AND FOR A SECOND CAUSE OF ACTION
AGAINST ALL DEFENDANTS
(BATTERY)

63. Plaintiff repeats, reiterates and realleges each and every allegation contained in paragraphs "1" though "62" hereinabove as if more fully set forth at length herein.

64. On or about March 12,2010, at approximately 5:55 P.M., in the area designed as Quad 10 Lower in the Anna M. Kross Center on Rikers Island, County of Bronx, City and State of New York, the individual defendants hereto, without probable cause to do so, offensively touched plaintiff by pepper-spraying him, mutilating his arm, handcuffing him, repeatedly stricking him, kicking him, punching him in the face and slaming him to the floor, cracking his tooth.

65. On or about May 4,2010, at approximately 10:40 A.M., in the area designed as 8A 23 cell in the George R. Vierno Center on Rikers Island, County of Bronx, City and State of New York, the individual defendants hereto, without probable cause to do so, offensively touched plaintiff by violently grabbing him from

the bunk, twisting his injured right arm, violently slapping him repeatedly, cuffing him.

66. The aforesaid force used by the individual defendants was not reasonable under the circumstances.

67. At the aforesaid time and place, the individual defendants were acting within the scope of their employment defendant CITY OF NEW YORK.

68. By reason of the aforesaid battery committed against him by the individual defendants, while they were acting within the scope of their employment by defendant CITY OF NEW YORK, plaintiff suffered, and continues to suffer, serious and permanent physical and emotional injuries and has required and continue to require medical treatment for his injuries.

69. As a result of the battery committed upon him by the individual defendants, while they were acting within the scope of their employment by defendant CITY OF NEW YORK, plaintiff has been damaged in the amount of Five Hundred Thousand ($500,000) Dollars and demands an additional Two Hundred Sixty Thousand ($260,000) Dollars as punitive damages against the individual defendants.

WHEREFORE, plaintiff, LEVAR T. HENRY, demands judgment against defendants, SECURITY CAPTAIN MICHEAL WILLAIMS, Shield No.820, CAPTAIN GAMBLE, Shield No.88, C.O. LEOCARDIO ARIAS, Shield No.17955, C.O. LAMAR, Shield No.18472, C.O. MOHR, Shield No.17362, ACTING WARDEN CARLTON NEWTON, CAPTAIN CRUZ, CAPTAIN MERCEL, Shield No.381, CAPTAIN KELLY, DEPUTY WARDEN ELISEO PEREZ, JR., CAPTAIN SHERMA DUNBAR, Shield No.717, C.O. CAMPBELL, Shield No.18645, CAPTAIN BANKS, Shield No. 819, C.O. JOHNSON,

Shield No.8461, C.O. MCKELLER, Shield No.10049, C.O. DAVIS, Shield No.15633, and THE CITY OF NEW YORK, as follows:

FIRST CAUSE OF ACTION: Five Hundred Thousand ($500,000.00) Dollars and an additional Two Hundred Sixty Thousand ($260,000.00) Dollars as punitive damages against the individual defendants;

SECOND CAUSE OF ACTION: Five Hundred Thousand ($500,000.00) Dollars and an additional Two Hundred Sixty Thousand ($260,000.00) Dollars as punitive damages against the individual defendants.

In addition, plaintiff demands the cost and disburements of this action, including his attorney's fee's (if an attorney is needed at trial or prior to trial), pursauant to 42 U.S.C. §1988.

Dated: Ossining, New York
April 5,2011

LEVAR T. HENRY
Plaintiff Pro Se
DIN: 10A4556
Sing Sing Corr. Facility
354 Hunter Street
Ossining, New York 10562

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK X

LEVAR T. HENRY,

Plaintiff,

-against-

SECURITY CAPTAIN MICHEAL WILLIAMS, et. al,

Defendants.
X

EXHIBITS

A - J

PAGES 1 to 163

*See EXHIBIT "J" for plaintiff medical records. Whatever medical record document not enclosed in "J" will be provided upon request.

EXHIBIT

A

PAGES 1 to 14

(1)

CLAIM AGAINST THE CITY OF NEW YORK

PERSONAL INJURY

This claim must be filed either in person or by registered or certified mail within 90 days from the date of occurrence at the Office of the Comptroller, Municipal Building, Room 1225 1 Centre Street, New York, N.Y. 10007.

To The Comptroller of The City of New York: I herewith present my claim against the City of New York.

TYPE or PRINT INFORMATION

PERSONAL INFORMATION

Name Of Claimant	Last	First	Age	Date of Birth Month Day Year	If Married, Spouse's Name
	HENRY	LEVAR	32	11/02/77	

Address Number & Street: 09-09 HAZEN STREET | City (Borough): EAST ELMHURST | State: NEW YORK | Zip: 11370 | Home Phone: ( ) N/A

ACCIDENT INFORMATION

Date Of Accident: 3/12/10 (Month Day Year) | Exact Location Of Accident: _____

Time: 1755 [ ] AM [X] PM | Describe How Accident Happened:

WHILE IN HAND CUFFS

Was There a Witness to Accident?	If Yes, Give Name: LAST	FIRST
[X] Yes [ ] No	BAKER	SEAN
	POPE	JAMES
	DESANTIS	LAWRENCE.

Address & Phone No. of Witness ( ): NUMBER & STREET 18-18 HAZEN STREET CITY (BOROUGH) E.ELMHURST STATE NY ZIP 11370 PHONE

Were Police Present at Accident [ ] Yes [ ] No | Police Officer: Name Of LAST FIRST BADGE # PRECINCT

2010 APR 16 PM 1:39 RECEIVED

MEDICAL INFORMATION

Where Was First Medical Treatment: ELMHURST HOSPITAL

Date Of First Medical Treatment: 03/13/10

SEE ATTACHED

Was Claimant Taken to Hospital By Ambulance? [X] YES [ ] NO | Was Claimant Admitted To Emergency Room? [X] YES [ ] NO

Name of Hospital: ELMHURST HOSPITAL | Date of Treatment: 03/13/10

Name of Doctor Treating Injury: N/A

Address Of Doctor: N/A

Describe Your Injury In Detail: HAND CUFFED, SPRAYED WITH MACE, PUNCHED AND STOMPED IN THE RIGHT SIDE OF HEAD, STAFF TRIED TO BREAK ARM(Right), KNOCKED OUT. TOOTH CRACKED ON RIGHT SIDE, KNEE INJURY.

EMPLOYMENT INFORMATION

Status At Time of accident [ ] Employed [X] Unemployed | Amount earned weekly $ _____

Number of days lost _____: [ ] Retired $ Lost (If any)

Employer's Name | _____ Employer's Address: _____

Your Security # [redacted] _____

DOCTOR AND HOSPITAL EXPENSES

Amount of Doctor Bills Submitted [ ] Yes [ ] No: Are Any Hospital Bills If Any Submitted [ ] Yes [ ] No: Amount of $ N/A

Are Bills submitted With Claim [ ] YES [X] NO: Amount: $ _____

COMPLETE THIS SECTION IF ACCIDENT INVOLVED NYC OWNED VEHICLE

Was Claimant the Owner of Vehicle Involved in Collision? N/A [ ] Yes [ ] No | If No: | Owner's Name: Last _____ First _____

Owner's Address _____

Was Claimant the Driver [ ] Yes [ ] No | Was Claimant a Passenger? [ ] Yes [ ] No

NYC VEHICLE AND DRIVER INFORMATION

Name of NYC Driver : Last N/A First _____ | NYC License Plate # _____

Employed By (Provide Name of City Agency) _____

TOTAL AMOUNT CLAIMED AS DAMAGES FOR ACCIDENT $ _____

Signature of Claimant X _____ Date: 4-13-10

STATE OF NEW YORK
COUNTY OF

I, LEVAR HENRY, being duly sworn deposes and says that I have read the foregoing NOTICE OF CLAIM and know the contents thereof; that same is true to the best of my own knowledge, except as to the matters therein stated to be alleged upon information and belief, and as to those matters, I believe them to be true.

Signature of If Claimant

Sworn to before me this 13 day of April 2010

ROSE F. OLANIYI
NOTARY PUBLIC STATE OF NEW YORK
No. 01OL6208822
Qualified in Queens County
My Commission Expires July 13, 2013

Signature of Notary Public

If Not Settled, You Must Start Legal Action Within One and 90 Days From Date of Accident.

(2)

THE LEGAL AID SOCIETY

Prisoners' Rights Project
199 Water Street
New York, NY 10038
T (212) 577-3530
F (212) 509-8433
www.legal-aid.org

April 16, 2010

Mr. Levar Henry
349-07-21085
George R. Vierno Center
09-09 Hazen Street
East Elmhurst, NY11370

Re: Notice of Claim

Dear Mr. Henry,

Please find herewith: 1) your time-stamped notice of claim form, which I filed at the New York City Comptroller's office this afternoon, and 2) copies of requests for your medical records, which I sent to CHS and Elmhurst Hospital. When I receive your medical records, I will send a copy to you.

The Prisoners' Rights Project is a small test case unit of the Legal Aid Society and we do not represent individual inmates in their individual lawsuits. We focus our limited resources on class action litigation challenging unconstitutional conditions of confinement in New York City jails and New York State prisons. In this manner, we are able to address the problems faced by large groups of individuals. However, please understand that we are not your lawyers, and that we do not represent you in this matter.

Very truly yours,

Joseph G. Cleemann
Law Graduate Extern

(3)

THE LEGAL AID SOCIETY

Prisoners' Rights Project
199 Water Street
New York, NY 10038
T (212) 577-3530
F (212) 509-8433
www.legal-aid.org

April 16, 2010

Ms. Juana Perez
Medical Records Access Officer
Correctional Health Services
Department of Health and Mental Hygiene
233 Broadway, 26th Floor
New York, New York 10007

Re: Levar Henry, 349-07-21085

Dear Ms. Perez:

Pursuant to the enclosed release for medical records, please send a complete copy of the medical records for Levar Henry, who is an inmate in custody of the Department of Correction.

This request also encompasses medical records which may be kept separately from the medical chart in another location, including, but not limited to, all Urgicare center, specialty clinic, and pharmacy administration records for this patient.

Thank you for your attention to this matter.

Sincerely,

JOSEPH CLEEMANN
Law Graduate Extern

Enclosure

(4)

THE LEGAL AID SOCIETY

Prisoners' Rights Project
199 Water Street
New York, NY 10038
T (212) 577-3530
F (212) 509-8433
www.legal-aid.org

April 16, 2010

Elmhurst Hospital Center
79-01 Broadway
Elmhurst, NY 11373
Attn: Medical Records

Re: Levar Henry, 349-07-21085

To Whom It May Concern:

Please send a complete copy of the medical records, including the outpatient clinic records and in-patient hospitalization records, scheduling and appointment records of Levar Henry , who is an inmate of the Department of Correction. Enclosed is a signed medical release authorizing disclosure of these records.

Thank you for your attention to this matter.

Sincerely yours,

JOSEPH CLEEMANN
Law Graduate Extern

Enclosure

(5)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS NCLUDING CONFIDENTIAL HIV RELATED INFORMATION

Patient (Print Name): Levar Henry Date of Birth: 11/2/77

Book and Case Number: 349-07-21085 NYSID Number 78 39962 Z

Date(s) of Incarceration: 11/15/07 - Present

Facility/Facilities: AMKC, GRVC, ALL

1. I hereby request and authorize the New York City Department of Health and Mental Hygiene Correctional Health Services ("CHS") to provide a copy of any medical, mental health and dental records relating to the treatment I received while incarcerated at the above facility or facilities, to the following Person(s) or Organization(s) whose full names and addresses are listed below **[Required]:**

   THE LEGAL AID SOCIETY
   199 WATER STREET, 6TH FLOOR
   NEW YORK, NY 10038

2. If the requested records contain information pertaining to drug or alcohol treatment or contain HIV related information, I specifically authorize the release of such information by initialing each of the following paragraphs. **If I do not initial each of the following paragraphs, CHS will remove the information described in that paragraph from the copy of records provided pursuant to this release.**

   LAA initials — I understand that if my records contain information concerning drug or alcohol treatment, this information will be released pursuant to this consent form.

   LAA initials — I understand that if my records contain confidential HIV related information, such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a person was administered an HIV test or has HIV infection, HIV related illness or AIDS, or is any information which could indicate a person has been potentially exposed to HIV.

3. Revocation of this authorization: I understand that I may revoke this authorization, in writing, at any time by delivering or sending a copy of the written revocation to CHS. I also understand that I may not revoke this authorization to the extent that CHS has already

(6)

Patient Name	Date of Birth	Social Security Number
Lever Henry	11/2/77	[redacted]
Patient Address: Apt C - 09-09 Mazen St. East Elmhurst NY		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Elmhurst Hospital (NYC-HHC)

8. Name and address of person(s) or category of person to whom this information will be sent:
Legal Aid - PRP - 199 Water Street NY NY 10038

9(a). Specific information to be released:

☐ Medical Record from (insert date) _____ to (insert date) _____

☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.

☐ Other: _____

Include: *(Indicate by Initialing)*

LA **Alcohol/Drug Treatment**

LA **Mental Health Information**

LA **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here LA (Initials) I authorize [redacted] Elmhurst Hospital (NYC-HHC) LA

Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

Legal Aid - PRP

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	1/1/2015
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

X [signature] Date: X 4/14/10

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

(7)

THE CITY OF NEW YORK OFFICE OF THE COMPTROLLER
1 CENTRE STREET, NEW YORK, N.Y. 10007-2341

John C. Liu
COMPTROLLER

015 - 196

Date: 05/24/2010
Claim no: 2010PI016336
Claimant: LEVAR HENRY

LEVAR HENRY
09-09 HAZEN ST -349-07-01085
EAST ELMHURST, NY 11370 -

Dear LEVAR HENRY:

This office is in receipt of your inquiry regarding your claim. In order to assist us in evaluating the
claim, please provide the following:

✓ Copies of hospital and doctor records indicating a diagnosis

___ Photos of the defect and area where you allegedly fell

___ Copies of bills and proof of payment to medical providers

___ Copies of your pay stubs & proof of lost wages from your employer

✓ Your social security number __ __ __ - __ __ - __ __ __ __

✓ Your date of birth __ __ / __ __ / __ __ __ __

___ Other: _____

If you have any questions, please contact me at (212) 669-4765
Please be advised that if we are unable to reach a settlement you must begin a lawsuit within one year and ninety days of the occurrence in order to preserve your rights under the law.

Sincerely,

Charles Castaldo

CHARLES CASTALDO
-- EXAMINER --

(8)

PERSONAL INJURY CLAIM FORM

Claim must be filed *in person or by registered or certified mail within 90 days of the occurrence* at the NYC Comptroller's Office 1 Centre St. Room 1225, New York, New York 10007. It must be *notarized*. If claim is not resolved within *1 yr and 90 days of the occurrence* you must start legal action to preserve your rights

To the Comptroller of the City of NY: I herewith present my claim against the City of New York
TYPE OR PRINT

PERSONAL INFORMATION

Last Name of Claimant HENRY First Name LEVAR

09-09 HAZEN STREET, E.ELMHURST, NY 11370
Address Borough Zip Code

11/02/77 [redacted] N/A
Date of Birth Social Security # Telephone #

N/A
Cell # Fax # E-Mail Address

ACCIDENT / INCIDENT INFORMATION

5/04/10-5/11/10
3/16/10-3/23/10 09-09 HAZEN ST.,E.ELMHURST,NY 11370(MHAUII/RIKERS ISLAND)
Date of Incident Exact Location of Incident

As a direct result of unlawful imposition,imprisonment and inforcement of wrongf
ully ~~given CPSU,Levar Henry has suffered actual damage in forms~~ involving, witho
ut limitation,mental anguish,pain & suffering. Mr.Henry was held 8 days in March
and ~~8 days in May. Henry owed NYCD no MHAUII/CPSU time prior~~ to these dates.
The NYCD's computer and/or staff keeps reissuing 8 days to Mr.Henry for no reaso
n. 16 total combined MHAUII/CPSU days,23hr. lock down. 8 days no phone.
Time ( ) AM ( ) PM Describe how incident happened

Names(s) of Witness(s)

Addresses of Witness(s)

Were Police present at accident site Yes ( ) No ( ) Police Report #

Police Officer's Names(s) Shield # Precinct

Please attach photos of accident scene and/or damage if available

MEDICAL INFORMATION

Date of First Treatment Location of first Medical Treatment

Was claimant taken by ambulance | Date treated in emergency room | Name of Hospital

Name and address of treating physician(s)

Describe injury in detail

Name & Address of your Health insurer Policy #

$ Total Out of Pocket Expenses | $ Doctors | $ Hospital | $ Other

Please attach related bills and receipts

(9)

EMPLOYMENT INFORMATION

Status on day of accident
Employed ( )
Unemployed ( )

Amount earned
weekly $ _____

Days lost
from work _____

Employer's Name | Address | Telephone

COMPLETE IF ACCIDENT INVOLVES A NYC OWNED VEHICLE

Was claimant the owner of the vehicle

If no, name & address of owner

Was claimant the
( ) driver
( ) passenger

Name & Address of Insurance Company

Policy #

Make, Model, Year of Car Claimant was in

Plate #

Registration #

Plate # of NYC Vehicle

City Agency Involved

Name of City Driver

MAY 25, 2010
Date

Signature of Claimant LEVAR HENRY

State of New York
County of BX.

I, Levar Henry, being duly sworn deposes and says that I have read the foregoing NOTICE OF CLIAM and know the contents thereof: that same is true to the best of my own knowledge, except as to the matter here stated to be alleged upon information and belief, and as to those matters, I believe them to be true

Signature of Claimant

LEVAR HENRY
349-07-21085
09-09 HAZEN STREET
E.EKMHURST, NY 11370

Sworn before me this day May 25 2010
Signature of notary

Andre Bethea
Notary Public State Of New York
Kings County
NO. 01BE6191493
Commission Expires Aug. 18 2012

(10)

PERSONAL INJURY CLAIM FORM

Claim must be filed *in person or by registered or certified mail within 90 days of the occurrence* at the NYC Comptroller's Office 1 Centre St. Room 1225, New York, New York 10007. It must be *notarized*. If claim is not resolved within *1 yr and 90 days of the occurrence* you must start legal action to preserve your rights

To the Comptroller of the City of NY: I herewith present my claim against the City of New York

TYPE OR PRINT

PERSONAL INFORMATION

Last Name of Claimant HENRY First Name LEVAR

09-09 HAZEN STREET, E.ELMHURST, NY 11370

Address Borough Zip Code

11/02/77 [redacted] N/A

Date of Birth Social Security # Telephone #

Cell # Fax # E-Mail Address

ACCIDENT / INCIDENT INFORMATION

5-20-10 09-09 HAZEN STREET, E.ELMHURST, NY 11370(RIKERS ISLAND)

Date of Incident Exact Location of incident

Time ( ) AM ( ) PM Describe how incident happened

PAIN IN FEET/FEET FUNGUS FROM CITY FOOT WEAR. NO SIZE 9-10. CLAIMANT HAS DIFFICULTY WALKING IN A CHEAP SHOE SINCE 12/08.

Names(s) of Witness(s)

Addresses of Witness(s)

Were Police present at accident site Yes ( ) No ( ) Police Report #

Police Officer's Names(s) Shield # Precinct

Please attach photos of accident scene and/or damage if available

MEDICAL INFORMATION

SEE RIKERS ISLAND MEDICAL FILE OF MR.HENRY.

Date of First Treatment Location of first Medical Treatment

Was claimant taken by ambulance | Date treated in emergency room | Name of Hospital

Name and address of treating physician(s)

Describe injury in detail

Name & Address of your Health Insurer Policy #

$ Total Out of Pocket Expenses | $ Doctors | $ Hospital | $ Other

Please attach related bills and receipts

EMPLOYMENT INFORMATION

Status on day of accident
Employed ( )
Unemployed ( )

Amount earned weekly $ _____

Days lost from work _____

Employer's Name Address Telephone

COMPLETE IF ACCIDENT INVOLVES A NYC OWNED VEHICLE

Was claimant the owner of the vehicle | If no, name & address of owner

Was claimant the
( ) driver
( ) passenger

Name & Address of Insurance Company Policy #

(11)

Make, Model, Year of Car Claimant was in | Plate # | Registration #

Plate # of NYC Vehicle | City Agency Involved | Name of City Driver

5/25/10
Date

Signature of Claimant LEVAR HENRY

State of New York
County of BRONX

I LEVAR HENRY, being duly sworn deposes and says that I have read the foregoing NOTICE OF CLIAM and know the contents thereof: that same is true to the best of my own knowledge, except as to the matter here stated to be alleged upon information and belief, and as to those matters, I believe them to be true

Signature of Claimant

LEVAR HENRY
349-0721085
09-09 HAZEN STREET
E.ELMHURST, NY 11370

Sworn before me this day May 25, 2010
Signature of notary

Andre Bethea
Notary Public State Of New York
Kings County
NO. 01BE6191493
Commission Expires Aug. 18 2012

(12)

THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
CLAIMS AND ADJUDICATIONS
1 CENTRE STREET ROOM 1200
NEW YORK, N.Y. 10007-2341

WWW.COMPTROLLER.NYC.GOV

Michael Aaronson
Chief, Bureau of Law and Adjustment

015 - 151

John C. Liu
COMPTROLLER

Date: 06/18/2010
Claim No: 2010PI021107
RE: Acknowledgment of Claim

LEVAR HENRY 3490721085
09-09 HAZEN ST
BRONX, NY 11370

Dear Claimant:

We acknowledge receipt of your claim, which has been assigned the claim number shown above. Please refer to this claim number in any correspondence or inquiry you may have with our office.

We will do our best to investigate and, if possible, settle your claim. However, if we are unable to resolve your claim, **any lawsuit against the City must be started within one year and ninety days from the date of the occurrence**.

If you have any questions regarding your claim, you may contact us at either 212-669-8750 for property damage claims or 212-669-4445 for claims involving personal injury.

Sincerely,
Michael Aaronson

(13)

THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
CLAIMS AND ADJUDICATIONS
1 CENTRE STREET ROOM 1200
NEW YORK, N.Y. 10007-2341

WWW.COMPTROLLER.NYC.GOV

Michael Aaronson
Chief, Bureau of Law and Adjustment

015 - 151

John C. Liu
COMPTROLLER

Date: 06/18/2010
Claim No: 2010PI021108
RE: Acknowledgment of Claim

LEVAR HENRY 3490721085
09-09 HAZEN ST
BRONX, NY 11370

Dear Claimant:

We acknowledge receipt of your claim, which has been assigned the claim number shown above. Please refer to this claim number in any correspondence or inquiry you may have with our office.

We will do our best to investigate and, if possible, settle your claim. However, if we are unable to resolve your claim, **any lawsuit against the City must be started within one year and ninety days from the date of the occurrence**.

If you have any questions regarding your claim, you may contact us at either 212-669-8750 for property damage claims or 212-669-4445 for claims involving personal injury.

Sincerely,
Michael Aaronson

(14)

TO: OFFICE OF THE COMPTROLLER
1 CENTRE STREET, RM# 1225 / RM# 1200
N.Y., N.Y. 10007-2341
FROM: MR. LEVAR HENRY #10A4556
SING SING CORR. FACILITY
354 HUNTER STREET
OSSINING, N.Y. 10562
DATE: JAN 2, 2011
RE: ADDRESS CHANGE

I WAS MOVED BACK TO SING SING CORRECTIONAL FACILITY AFTER A COURT DATE ON DECEMBER 31, 2010.

CLAIM No. 2010PI016336
CLAIM No. 2010PI021107
CLAIM No. 2010PI021108

IF POSSIBLE, PLEASE ADVISE OF THE CURRENT STATUS OF THESE CLAIM NUMBERS LISTED.

SINCERELY,

cc: File

EXHIBIT

B

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX

----------X

Levar Henry, Book & Case Number 349-07-21085,

Petitioner,

-against-

Index #340392-08

NYC Department of Correction, Warden of OBCC/CPSU

Respondent.

----------X

It is hereby stipulated and agreed to by the parties off record on September 19, 2008 as follows:

Petition is sustained regarding infraction 092308. Any punitive segregation time imposed is vacated. All Good time lost is restored.

The twenty-five dollar disciplinary fee is to be refunded to the inmates account, forthwith.

It is further agreed that any and all reference to this infraction will immediately be expunged from the inmate's record.

Dated: September 19, 2008

So Ordered,

A.J.S.C.

Faye Yelardy for
NYC DEPARTMENT OF
CORRECTIONS

Amber M. Ramanauskas, Legal Aid Society for
PETITIONER LEVAR HENRY

EXHIBIT

C

PAGES 16 to 17

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TRACIE A. SUNDACK & ASSOCIATES, L.L.C.
ATTORNEYS AT LAW

19 COURT STREET
THIRD FLOOR
WHITE PLAINS, NEW YORK 10601

TRACIE A. SUNDACK

JEFFREY R. POLLACK
ALBERT PIZZIRUSSO

WEB: SUNDACKLAW.COM

TEL: (914) 946-8100
(212) 267-8400
FAX: (914) 946-9585

April 9, 2010

Mr. Levar Henry
B/C#: 349-07-21085
18-18 Hazen Street
East Elmhurst, New York 11370

Dear Mr. Henry:

I am in receipt of a letter from Mr. James Pope stating you were also involved in an incident and your request for representation. Please be advised that after a review of the paperwork, I find that I will be unable to represent you on your claim. However, that does not mean you do not have a viable claim and suggest you contact another attorney immediately.

Thank you for considering my firm for representation.

Very truly yours,

Tracie A. Sundack /e

Tracie A. Sundack

TAS:ec

WITNESSES

1- Sean Baker, B&C#825-08-02525, NYSID#00753055Y

2- James Pope B&C#241-10-01941, NYSID#08871121R

3- Rene Saury, B&c#241-09-12325, NYSID#01309781Y

4- E. Pedroza, B&C#875-09-01126

5- Lawrance Desantis, B&C#441-10-00719

6- J. Rivera, B&C#241-07-11766

7- Thompson, Quad 10 Lower 7 Cell

8- Youmans, Quad 10 Lower 18 Cell

9- Ward, S., Quad 10 Lower

10- Caldwell, Quad 10 Lower 29 Cell

11- Joseph, Quad 10 Lower 2 Cell

12- Nevez, Quad 10 Lower 6 Cell

13- Tyrone White, B&C#825-10-00582, #6 Pen

14- Victor Phillips, B&C#349-10-00741, #6 Pen

15- Julius Curry, B&C#349-09-04153, #6 Pen

16- Captain Shannon, Shield No.1628

17- C.O. Bryant

18- C.O. McFarlin

EXHIBIT

D

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Henry, Levar
DOB: 11/07/1977 32Y M
V#: 2886097-1 ADM: 03/13/10

EXHIBIT

E

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GRIEVANT'S STATEMENT FORM

FACILITY: **ANNA M. KROSS CENTER (AMKC)** GRIEVANCE# _____

GRIEVANT'S NAME LEVAR HENRY B&C 349-07-21085

CATEGORY _____ HOUSING AREA Q6L DATE 3-16-10

All grievances must be submitted within 10 business days of incident and should be handwritten by the grievant only. This sheet should be used as a worksheet from which the grievance is typed onto the "Inmate Grievance Form" and remains filed in the Grievant's folder.

Grievance: ON 3-12-10 I WAS ASSULTED AT Q10LOWER BY CO'S FOR NO REASON; I HAD TO GO TO THE HOSPITAL TO BE TREATED FOR MY INJURIES. THE CO's TRIED TO BREAK MY ARM AND I WAS STOMPED IN THE FACE, SPRAYED WITH MACE WHILE IN HAND CUFFS. I WAS ALSO PUNCHED IN THE FACE BY CAPT.WILLIAMS#820 in the INTAKESHOWER AREA I WAS STILL IN HAND CUFFS. THIS INCIDENT WAS NOT MY FAULT BUT RETAILATION I FEEL FOR BEATING A RED ID INFRACTION SUPERVISED BY WILLIAMS IN2008. I AM IN PAIN.

Receipt #_____

Action Requested: PLEASE INVESTIGATE AND DO WHAT IS JUST AND PROPER. PLEASE BE FAIR AND UNDERSTAND THAT MR.HENRY DID NIT DESERVE THIS TREATMENT OR INFRACTION (IF GIVEN), or PHD STATUS.

Have you filed this grievance with any other Agency or Court? _____ Yes X No

Have you filed this grievance with the Inspector General's Office? _____ Yes X No

_____ Grievant agrees to have his/her statement edited for clarification by IGRC Staff.

_____ I am requesting that the grievance be written for me by the IGRC staff.

Dated: MARCH 16, 2010

Grievant's Signature LEVAR HENRY

Witnessed By

Sworn to before me
this 16 day of March 2010

NOTARY PUBLIC

MATTHEW REDDICK
NOTARY PUBLIC, State of New York
No. 01RE5076313
Qualified in Queens County
Expires April 21, 2011

Form #3375-A

EXHIBIT

F

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CITY OF NEW YORK
DEPARTMENT OF CORRECTION

FACILITY: A.M.K.C. DATE: 3/13/2010 HOUSING LOCATION: QL10

INMATE NAME: Henry, Levar BOOK & CASE # 3490721085

CELL/BED #15

CHECK APPLICABLE BOX (ES):

THE UNDERSIGNED HEREBY CERTIFIES THAT: THE LIVING QUARTER [ ] AND THE PERSON [ ] AND CLOTHING [ ] OF THE ABOVE NAMED INMATE HAS BEEN SEARCHED. CONTRABAND FOUND HAS BEEN NOTED AND WAS IMMEDIATELY MARKED FOR PROPER IDENTIFICATION. IT WAS DELIVERED TO THE DEPUTY WARDEN FOR SECURITY. ANY DAMAGED DEPARTMENTAL AND/OR PERSONAL PROPERTY HAS BEEN NOTED AND FORWARDED TO THE DEPUTY WARDEN FOR SECURITY.

DESCRIPTION OF CONTRABAND FOUND

[X] NONE

[ ] YES — (Describe contraband found)

REASON FOR SEARCH: First

TITLE AND SIGNATURE OF OFFICER CONDUCTING SEARCH SHIELD # 8588

TITLE AND SIGNATURE OF SUPERIOR OFFICER SUPERVISING SEARCH SHIELD # 33

TITLE AND SIGNATURE OF SUPERIOR OFFICER AUTHORIZING SEARCH SHIELD #

EXHIBIT

G

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CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name [illegible] DOB [illegible]

FROM [illegible] [illegible]
Correctional institution Inmate no.

Referred to FOR DOC Ward / Clinic

Hospital / Clinic no.

Leave blank for hospital use

FOR DOC

Chief complaint or findings:

[illegible]

Diagnosis, treatment and medications by C.H.S.:

[illegible] for years

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Lester Lieberman, MD

Lester Lieberman, MD

Request:

Date 3/22/10 Referring Physician [signature] Phone ____ Approved ____

Consultation, findings and recommendations:

Date ____ Physician ____

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

EXHIBIT

H

PAGES 22 to 24

(22)

03/22/10 09:31

THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

GRVC

HENRY,LEVAR
ID#3490721085

COMMISSARY PURCHASE

REFERENCE NUMBER:1227496555

ITEM	PRICE	#	TOTAL
PEN	$ 0.42	1	$ 0.42
DIAL	$ 0.62	1	$ 0.62
CLOSE-UP	$ 1.25	1	$ 1.25
TOTAL	------	--	$ 2.29

HELP HAITI

~~13B23~~

$/Clinic

(23)

03/22/10 09:31

THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

GRVC

HENRY,LEVAR
ID#3490721085

PHONE CALLS SINCE 03/02/10 12:50

TIME	TELEPHONE #	MI	AMOUNT
03/02/10 21:54	(212) [redacted]	15	0.96
03/03/10 22:21	(212) [redacted]	1	0.52
03/03/10 22:21	(212) [redacted]	15	0.96
03/05/10 22:36	(212) [redacted]	15	0.96
03/06/10 11:17	(212) [redacted]	6	0.63
03/09/10 22:06	(718) [redacted]	6	0.63
03/11/10 22:21	(212) [redacted]	6	0.63
03/12/10 10:13	(212) [redacted]	6	0.63
03/16/10 09:06	(212) [redacted]	4	0.56
03/20/10 19:02	(212) [redacted]	6	0.63
03/21/10 17:54	(212) [redacted]	6	0.63
			7.74

HELP HAITI

♥

(24)

03/25/10 13:32

THE CITY OF NEW YORK
DEPARTMENT OF CORRECTION

GRVC

HENRY,LEVAR
ID#3490721085

PHONE CALLS SINCE 03/22/10 09:31

TIME	TELEPHONE #	MI	AMOUNT
03/22/10 20:32	(212)[redacted]	1	0.52
03/23/10 22:33	(212)[redacted]	15	0.96
03/24/10 20:41	(646)[redacted]	2	0.52
03/24/10 20:56	(212)577-3530	6	0.63
			2.63

HELP HAITI

♥

EXHIBIT

I

PAGES 25 to 29

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May 20, 2010

Dear Levar Henry,

Prisoner's Rights brought to my attention that you have been placed in PHD a few times absent any justification. Please write me with the details. Also, enclosed is information regarding PRS and a class action suit that is pending for those detained on illegal PRS. I thought you might find this of interest.

Best,

Barbara Hamilton
LAS
Staff Attorney

(Formerly, Ms. M from C-95 Law Library.)

(26)

CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Page 2 of 2 Pages

Form: 6500D
Rev.: 02/09/07
Ref.: Dir. #6500R-B

DOCUMENTARY EVIDENCE (Where applicable)

Photograph of Injury:	☐ Yes ☑ No		Shown to Inmate: ☐ Yes ☑ No
Photocopy of Weapon:	☑ Yes ☐ No	2" scapel blade	Shown to Inmate: ☑ Yes ☐ No
Reports - Specify Types:	☑ Yes ☐ No	6500A+B, Incident Report, Synopsis Report	Shown to Inmate: ☑ Yes ☐ No
Logbooks - Specify Types:	☐ Yes ☑ No		Shown to Inmate: ☐ Yes ☑ No
Infraction Investigation:	☑ Yes ☐ No	Capt. Montrose	Shown to Inmate: ☑ Yes ☐ No
Physical Evidence (List):	☐ Yes ☑ No		Shown to Inmate: ☐ Yes ☑ No
Witness Statements (List Witnesses):	☑ Yes ☐ No	(1) Stevenson, J 241-07-18684 (2) Peoples, A 113-08-00325 (3) Knight, A 895-07-0411	Shown to Inmate: ☑ Yes ☐ No

On this date and time following disposition was reached after a hearing on the charges listed below:

Charge #	Dismissed	Guilty	Penalty	Basis for Findings & Evidence Relied On
103.10		✓	60 days MS	Based on officer Lewis # 10537 eyewitness account, he witnessed inmate Henry, Kevin # 349-07-21085 remove a piece of paper from the back of his pants and throw it on the floor. After investigation concurs with the report officer and a Synopsis Report shows a 2" scapel blade was recovered, I substantiate the charge.

Total 60 days MS

Twenty Five Dollar ($25) Disciplinary Surcharge Grade I or Grade II offenses only: ☒ Yes ☐ No

If you have been found guilty of multiple rule violations, these penalties will be served: ☒ Consecutively ☐ Concurrently

Infraction Dismissed: ☐ Yes ☐ No

Reason:

Pre-Hearing Detention Time Credit: 5 Days.

Adjudication Captain (Print Name, Rank, Shield #): Capt. Cruz 807

Signature of Adjudication Captain: Capt. Cruz 807

You have the right to appeal an adverse decision rendered by the Adjudication Captain within two (2) days of service of this decision. If you have been sentenced to a total of thirty (30) days or more of punitive segregation or loss of all your good time on any one (1) Notice of Disciplinary Disposition (6500D), your appeal shall be forwarded to the General Counsel in the Legal Division. Within five (5) business days of the receipt of your appeal, you will receive a written decision from the General Counsel regarding such appeal unless further documentation/information is required by the General Counsel to decide your appeal. In those cases, the five (5) business day time limit shall be extended and the reasons for the extension will be noted on the General Counsel's decision to you. If you receive an unfavorable decision from the General Counsel or you do not receive a decision from the General Counsel within ten (10) business days of receipt of your appeal, you may file a petition for a writ under Article 78 of the CPLR. If you are sentenced to less that thirty (30) days punitive segregation or loss of less than all your good time, you may appeal that decision to the Warden of the facility where the infraction occurred.

I certify that I received a copy of this notice:	Signature of Inmate: Refused to sign	B&C/Sentence #: 3490721085	Date: 3-26-08	Time: 2256
Served by (Print Name, Rank and Shield #): Harris Capt. #82		Signature of Server: [signature]		
Refused to Sign for Notice: ☒ Yes ☐ No		Witnessed By: [signature] 13257		

P.H.D. RED I.D.

CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Page 1 of 2 Pages

Form: 6500D
Rev.: 02/09/07
Ref.: Dir. #6500R-B

Infraction #:

Inmate Name (Last, First): Henry, Lenar

Institution: OBCC/CPSU

Location: 3 South

B&C/Sentence #: 3490701085

NYSID #: 78349622

Adjudication Captain (Print Name, Rank & Shield #): Capt Cruz

Disposition Date: 3/26/08

Disposition Time: 1105 Hrs.

Tape Data (Tape #): 28/08

Counter # at Start: 617

Counter # at End: 721

Inmate's Accompanying card indicates Inmate Received Rule Book: ☐ Yes ☐ No

Inmate requested Witness(es): ☐ Yes ☒ No ☐ Waived ☐ Request Granted ☐ Denied (If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate requested Hearing Facilitator: ☐ Yes ☒ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, Hearing Facilitator must sign. If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate Requested Interpreter: ☐ Yes ☒ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, Interpreter must sign. If waived, inmate must sign If denied, state reason.)

Reason:

If inmate advised of right to remain silent was inmate advised that statements could be used against him/her. ☐ Yes ☐ No ☐ Not Applicable

Special Situations

Hearing in Absentia: ☐ Inmate Refused to Appear ☐ Removed from Hearing Due to

Adjournment: ☐ By Adjudication Captain Date Reconvened __ / __ / __ Specify Reason

☐ By Inmate Waived Time Limits to Facilitate Adjournment (Inmate Signature)

Referral: ☐ Security ☐ Mental Health ☐ Inspector General

Inmate Pled: ☐ Guilty ☒ Not Guilty ☐ Guilty with an Explanation

Summary of inmate's Testimony: I was in the dayroom playing games and the search team came in and Told us To get against the wall and I saw something Fly by me and the officer came in and he patted me. I didn't have this piece of paper that was covered with plastic.

The following witness(es) testified at your hearing. (If additional witnesses testified, attach additional sheets.)

Witness Name (Last Name, First Name):

Witness Signature (Present at Hearing):

Rank/Title, Shield/ID # (if staff), B&C/Sentence # (if inmate):

Witness testified in the presence of the charged inmate: ☐ Yes ☐ No If no, state reason:

Summary of Testimony:

Testimony was: ☐ Credited ☐ Rejected Reason:

Witness Name (Last Name, First Name):

Witness Signature (Present at Hearing):

Rank/Title, Shield/ID # (if staff), B&C/Sentence # (if inmate):

Witness testified in the presence of the charged inmate: ☐ Yes ☐ No If no, state reason:

Summary of Testimony:

Testimony was: ☐ Credited ☐ Rejected Reason:

CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Form: 6500D
Rev.: 02/09/07
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DOCUMENTARY EVIDENCE (Where applicable)

			Shown to Inmate:
Photograph of Injury:	☐ Yes	☑ No	☐ Yes ☑ No
Photocopy of Weapon:	☐ Yes	☑ No	☐ Yes ☑ No
Reports - Specify Types:	☑ Yes	☐ No C5 Report	☑ Yes ☐ No
Logbooks - Specify Types:	☐ Yes	☑ No	☐ Yes ☑ No
Infraction Investigation:	☑ Yes	☐ No CPT. Fenebee	☑ Yes ☐ No
Physical Evidence (List):	☐ Yes	☑ No	☐ Yes ☑ No
Witness Statements (List Witnesses):	☐ Yes	☑ No	☐ Yes ☑ No

On this date and time following disposition was reached after a hearing on the charges listed below:

Charge #	Dismissed	Guilty	Penalty	Basis for Findings & Evidence Relied On
101.10	✓	✓		
120.10 ✓ 120.14	✓	✓		ACQUITTED
115.11	✓	✓		

Twenty Five Dollar ($25) Disciplinary Surcharge Grade I or Grade II offenses only: ☐ Yes ☐ No

If you have been found guilty of multiple rule violations, these penalties will be served: ☐ Consecutively ☐ Concurrently

Infraction Dismissed: ☑ Yes ☐ No

Reason: ACQUITTED

Based on Captain Fenebee investigation he/she did not give any evidence of inmate Henry speaking other Freedoms or inmate Henry did not have I.D card to produce because it was confiscated in AMKC on 11/18/07

Pre-Hearing Detention Time Credit: before he went to Court Days.

Adjudication Captain (Print Name, Rank, Shield #):	Signature of Adjudication Captain:
Capt Cortez 860	Capt Cortez 860

You have the right to appeal an adverse decision rendered by the Adjudication Captain within ~~two~~ (2) days of service of this decision. If you have been sentenced to a total of thirty (30) days or more of punitive segregation or loss of all your good time on any one (1) Notice of Disciplinary Disposition (6500D), your appeal shall be forwarded to the General Counsel in the Legal Division. Within five (5) business days of the receipt of your appeal, you will receive a written decision from the General Counsel regarding such appeal unless further documentation/information is required by the General Counsel to decide your appeal. In those cases, the five (5) business day time limit shall be extended and the reasons for the extension will be noted on the General Counsel's decision to you. If you receive an unfavorable decision from the General Counsel or you do not receive a decision from the General Counsel within ten (10) business days of receipt of your appeal, you may file a petition for a writ under Article 78 of the CPLR. If you are sentenced to less that thirty (30) days punitive segregation or loss of less than all your good time, you may appeal that decision to the Warden of the facility where the infraction occurred.

I certify that I received a copy of this notice:	Signature of Inmate:	B&C/Sentence #:	Date:	Time:
Served by (Print Name, Rank and Shield #):		Signature of Server:		
Refused to Sign for Notice: ☐ Yes ☐ No		Witnessed By:		

CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Form: 6500D
Rev.: 02/09/07
Ref.: Dir. #6500R-B

Infraction #: 3729/08

Institution: AMKC

Inmate Name (Last, First): Henry, Levar

Location: QU10

B&C/ Sentence #: 3490721083

NYSID #: 7839962Z

Disposition Date: 11/20/08

Disposition Time: 1115 Hrs.

Adjudication Captain (Print Name, Rank & Shield #): Capt Cruz 1827

Tape Data (Tape #): 188/04

Counter # at Start: 379

Counter # at End: 457

Inmate's Accompanying card Indicates Inmate Received Rule Book: ☐ Yes ☐ No

Inmate requested Witness(es): ☐ Yes ☒ No ☐ Waived ☐ Request Granted ☐ Denied (If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate requested Hearing Facilitator: ☐ Yes ☒ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, Hearing Facilitator must sign. If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate Requested Interpreter: ☐ Yes ☒ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, interpreter must sign. If waived, inmate must sign. If denied, state reason.)

Reason:

If inmate advised of right to remain silent was inmate advised that statements could be used against him/her. ☐ Yes ☐ No ☐ Not Applicable

Special Situations

Hearing in Absentia: ☐ Inmate Refused to Appear ☐ Removed from Hearing Due to

Adjournment: ☐ By Adjudication Captain Date Reconvened __/__/__ Specify Reason

☐ By Inmate Waived Time Limits to Facilitate Adjournment (Inmate Signature)

Referral: ☐ Security ☐ Mental Health ☐ Inspector General

Inmate Pled: ☐ Guilty ☒ Not Guilty ☐ Guilty with an Explanation

Summary of Inmate's Testimony:

I never got a Ticket, but I remember the incident. Somebody threw something on the gates and the officer [illegible] on the [illegible] and got something in her shirt. they asked me for my I.D. card and I told them they took my I.D. card Early that morning in AMKC. I think that why they wrote me up because I didn't have a I.D.

The following witness(es) testified at your hearing. (If additional witnesses testified, attach additional sheets.)

Witness Name (Last Name, First Name):

Rank/Title, Shield/ID # (if staff), B&C/Sentence # (If inmate):

Witness Signature (Present at Hearing):

Witness testified in the presence of the charged inmate: ☐ Yes ☐ No If no, state reason:

Summary of Testimony:

Testimony was: ☐ Credited ☐ Rejected Reason:

Witness Name (Last Name, First Name):

Rank/Title, Shield/ID # (if staff), B&C/Sentence # (if inmate):

Witness Signature (Present at Hearing):

Witness testified in the presence of the charged inmate: ☐ Yes ☐ No If no, state reason:

Summary of Testimony:

Testimony was: ☐ Credited ☐ Rejected Reason:

(28)

STARTED TIME ON JUNE 2nd 2009 AT GRVC CPSU - RELEASE 9-10-09 ?
349 07 21085

EXHIBIT D

CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Form: 6500D
Rev.: 02/09/07
Ref.: Dir. #6500R-B

DOCUMENTARY EVIDENCE (Where applicable)

Photograph of Injury:	☐ Yes ☐ No	Shown to Inmate: ☐ Yes ☐ No
Photocopy of Weapon:	☐ Yes ☐ No	Shown to Inmate: ☐ Yes ☐ No
Reports - Specify Types:	☑ Yes ☐ No 6500 / B injury reports	Shown to Inmate: ☐ Yes ☐ No
Logbooks - Specify Types:	☐ Yes ☐ No	Shown to Inmate: ☐ Yes ☐ No
Infraction Investigation:	☑ Yes ☐ No	Shown to Inmate: ☐ Yes ☐ No
Physical Evidence (List):	☐ Yes ☑ No	Shown to Inmate: ☐ Yes ☐ No
Witness Statements (List Witnesses):	☐ Yes ☐ No	Shown to Inmate: ☐ Yes ☐ No

On this date and time following disposition was reached after a hearing on the charges listed below: 2/25/09 -

Charge #	Dismissed	Guilty	Penalty	Basis for Findings & Evidence Relied On
101.14	—	✓	90 Ds	Based on officer Manners written and reported on the account of your action
120.10	—	✓	11 Ds	reported on 2/19/09 the injury report on inmate Vasquez injuries. Captain Bowden investigation which in conclusion substantiated the charges
101 Ds				

Twenty Five Dollar ($25) Disciplinary Surcharge Grade I or Grade II offenses only: ☑ Yes ☐ No

If you have been found guilty of multiple rule violations, these penalties will be served: ☑ Consecutively ☐ Concurrently

Infraction Dismissed: ☐ Yes ☑ No

Reason:

Pre-Hearing Detention Time Credit: _______ Days.

Adjudication Captain (Print Name, Rank, Shield #): [signature] | Signature of Adjudication Captain: [signature]

You have the right to appeal an adverse decision rendered by the Adjudication Captain within two (2) days of service of this decision. If you have been sentenced to a total of thirty (30) days or more of punitive segregation or loss of all your good time on any one (1) Notice of Disciplinary Disposition (6500D), your appeal shall be forwarded to the General Counsel in the Legal Division. Within five (5) business days of the receipt of your appeal, you will receive a written decision from the General Counsel regarding such appeal unless further documentation/information is required by the General Counsel to decide your appeal. In those cases, the five (5) business day time limit shall be extended and the reasons for the extension will be noted on the General Counsel's decision to you. If you receive an unfavorable decision from the General Counsel or you do not receive a decision from the General Counsel within ten (10) business days of receipt of your appeal, you may file a petition for a writ under Article 78 of the CPLR. If you are sentenced to less that thirty (30) days punitive segregation or loss of less than all your good time, you may appeal that decision to the Warden of the facility where the infraction occurred.

I certify that I received a copy of this notice:	Signature of Inmate: [signature]	B&C/Sentence #: 3490721088	Date: 2-25-09	Time: 2047
Served by (Print Name, Rank and Shield #): 349 07 2108 [signature] CAPT [illegible]		Signature of Server: [signature]		
Refused to Sign for Notice: ☐ Yes ☐ No		Witnessed By:		

CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Page 1 of 2 Pages

Form: 6500D
Rev.: 02/09/07
Ref.: Dir. #6500R-B

Infraction #: 622/09

Institution: AMKC

Inmate Name (Last, First): Henry, Levine

B&C/ Sentence #: 3490101085

NYSID #: 783[illegible]

Location: [illegible]

Disposition Date: 2/25/09

Disposition Time: 1142 Hr

Adjudication Captain (Print Name, Rank & Shield #): [illegible]

Tape Date (Tape #): 2/25/09

Counter # at Start: 004

Counter # at End: 351

Inmate's Accompanying card Indicates Inmate Received Rule Book: ☐ Yes ☐ No

Inmate requested Witness(es): ☑ Yes ☐ No ☐ Waived ☐ Request Granted ☐ Denied (If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate requested Hearing Facilitator: ☐ Yes ☑ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, Hearing Facilitator must sign. If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate Requested Interpreter: ☐ Yes ☑ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, Interpreter must sign. If waived, inmate must sign. If denied, state reason.)

Reason:

If inmate advised of right to remain silent was inmate advised that statements could be used against him/her. ☐ Yes ☐ No ☐ Not Applicable

Special Situations

Hearing in Absentia: ☐ Inmate Refused to Appear ☐ Removed from Hearing Due to ______ Specify Reason

Adjournment: ☐ By Adjudication Captain Date Reconvened ___/___/___

☐ By Inmate Waived Time Limits to Facilitate Adjournment (Inmate Signature) ______

Referral: ☐ Security ☐ Mental Health ☐ Inspector General

Inmate Plea: ☐ Guilty ☑ Not Guilty ☐ Guilty with an Explanation

Summary of Inmate's Testimony: Capt [illegible] - The incident I had was not in the dayroom. I wasn't involve in that incident. Early that day I got [illegible] three [illegible] I got [illegible] the [illegible] but [illegible] there was another fight [illegible]

The following witness(es) testified at your hearing. (If additional witnesses testified, attach additional sheets.)

Witness Name (Last Name, First Name): [illegible]

Rank/Title, Shield/ID # (if staff), B&C/Sentence # (if inmate): [illegible]

Witness Signature (Present at Hearing): [illegible]

Witness testified in the presence of the charged inmate: ☑ Yes ☐ No If no, state reason:

Summary of Testimony: What occur happen in the dayroom [illegible] [illegible] fighting [illegible] in the dayroom [illegible] [illegible] I believe he was [illegible] [illegible] the fight [illegible]

Testimony was: ☐ Credited ☑ Rejected Reason: [illegible] Base on testimony was not [illegible]

Witness Name (Last Name, First Name):

Rank/Title, Shield/ID # (if staff), B&C/Sentence # (if inmate):

Witness Signature (Present at Hearing):

Witness testified in the presence of the charged inmate: ☐ Yes ☐ No If no, state reason:

Summary of Testimony:

Testimony was: ☐ Credited ☐ Rejected Reason:

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CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Page 2 of 2 Pages | Form: 6500D | Rev.: 02/09/07 | Ref.: Dir. #6500R-B

DOCUMENTARY EVIDENCE (Where applicable)

Photograph of Injury:	☐ Yes ☒ No	Shown to Inmate:	☐ Yes ☒ No
Photocopy of Weapon:	☐ Yes ☒ No	Shown to Inmate:	☐ Yes ☒ No
Reports - Specify Types:	☒ Yes ☐ No 6500A	Shown to Inmate:	☒ Yes ☐ No
Logbooks - Specify Types:	☐ Yes ☒ No	Shown to Inmate:	☐ Yes ☒ No
Infraction Investigation:	☒ Yes ☐ No 6500B	Shown to Inmate:	☒ Yes ☐ No
Physical Evidence (List):	☒ Yes ☐ No Photo of test	Shown to Inmate:	☒ Yes ☐ No
Witness Statements (List Witnesses):	☐ Yes ☒ No	Shown to Inmate:	☐ Yes ☒ No

On this date and time following disposition was reached after a hearing on the charges listed below: 7/14/08

Charge #	Dismissed	Guilty	Penalty	Basis for Findings & Evidence Relied On
130.11		✓	50 Days PS	Based on the report of CO Barnes that states your urine tested positive for THC, the physical evidence the photo of the urine you provided and the positive results and Capt. Montana's investigation I find you guilty.

50 Days PS

Twenty Five Dollar ($25) Disciplinary Surcharge Grade I or Grade II offenses only: ☒ Yes ☐ No

If you have been found guilty of multiple rule violations, these penalties will be served: N/A ☐ Consecutively ☐ Concurrently

Infraction Dismissed: ☐ Yes ☒ No

Reason:

Pre-Hearing Detention Time Credit: N/A Days.

Adjudication Captain (Print Name, Rank, Shield #): Wilson Capt. 546 | Signature of Adjudication Captain:

You have the right to appeal an adverse decision rendered by the Adjudication Captain within two (2) days of service of this decision. If you have been sentenced to a total of thirty (30) days or more of punitive segregation or loss of all your good time on any one (1) Notice of Disciplinary Disposition (6500D), your appeal shall be forwarded to the General Counsel in the Legal Division. Within five (5) business days of the receipt of your appeal, you will receive a written decision from the General Counsel regarding such appeal unless further documentation/information is required by the General Counsel to decide your appeal. In those cases, the five (5) business day time limit shall be extended and the reasons for the extension will be noted on the General Counsel's decision to you. If you receive an unfavorable decision from the General Counsel or you do not receive a decision from the General Counsel within ten (10) business days of receipt of your appeal, you may file a petition for a writ under Article 78 of the CPLR. If you are sentenced to less that thirty (30) days punitive segregation or loss of less than all your good time, you may appeal that decision to the Warden of the facility where the infraction occurred.

I certify that I received a copy of this notice:	Signature of Inmate:	B&C/Sentence #: 349-07-21055	Date: 7-14-08	Time: 1950 hrs
Served by (Print Name, Rank and Shield #): Cruz [illegible]		Signature of Server:		
Refused to Sign for Notice: ☐ Yes ☒ No		Witnessed By:		

7/14/08 0945

CORRECTION DEPARTMENT
CITY OF NEW YORK

HEARING REPORT AND NOTICE OF DISCIPLINARY DISPOSITION

Page 1 of 2 Pages | Form: 6500D Rev.: 02/09/07 Ref.: Dir. #6500R-B

Infraction #: 2108/08 | Institution: ANKC

Inmate Name (Last, First): Henry, Lever | B&C/ Sentence #: 349-07-21085 | NYSID #: 7839962Z

Location: QH1B | Disposition Date: | Disposition Time: Hrs.

Adjudication Captain (Print Name, Rank & Shield #): Capt. Wilson 54

Tape Data (Tape #): 118/08 | Counter # at Start: 095 | Counter # at End: 264

Inmate's Accompanying card Indicates Inmate Received Rule Book: ☐ Yes ☐ No

Inmate requested Witness(es): ☑ Yes ☐ No ☐ Waived ☐ Request Granted ☐ Denied (If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate requested Hearing Facilitator: ☐ Yes ☑ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, Hearing Facilitator must sign. If waived, inmate must sign. If denied, state reason.)

Reason:

Inmate Requested Interpreter: ☐ Yes ☑ No ☐ Waived ☐ Request Granted ☐ Denied (If yes, interpreter must sign. If waived, inmate must sign. If denied, state reason.)

Reason:

If inmate advised of right to remain silent was inmate advised that statements could be used against him/her. ☐ Yes ☐ No ☐ Not Applicable

Special Situations

Hearing in Absentia: ☐ Inmate Refused to Appear ☐ Removed from Hearing Due to

Adjournment: ☐ By Adjudication Captain Date Reconvened ___/___/___ Specify Reason

☐ By Inmate Waived Time Limits to Facilitate Adjournment (Inmate Signature)

Referral: ☐ Security ☐ Mental Health ☐ Inspector General

Inmate Pled: ☐ Guilty ☑ Not Guilty ☐ Guilty with an Explanation

Summary of Inmate's Testimony: That it was a panic line. Capt. Williams came into the room and spoke to the officer. The test was not done.

The following witness(es) testified at your hearing. (If additional witnesses testified, attach additional sheets.)

Witness Name (Last Name, First Name): ~~Fisher~~ WALKER, DEON | Rank/Title, Shield/ID # (if staff), B&C/Sentence # (if inmate): Anthony 441.05.07407

Witness Signature (Present at Hearing): X ~~Anthony Fisher~~ 441.05.0889 4

Witness testified in the presence of the charged inmate: ☑ Yes ☐ No If no, state reason:

Summary of Testimony: Mr Henry went to the bathroom. The CO Dip the stick in there and was able to see the lines. I saw clear. He was showing me his line. The top of the second stick in there he showed me his stick.

Testimony was: ☐ Credited ☑ Rejected Reason: Not definite that it was inmate Henry's stick.

Witness Name (Last Name, First Name): Fisher, Anthony | Rank/Title, Shield/ID # (if staff), B&C/Sentence # (if inmate): 441.05.05897

Witness Signature (Present at Hearing): X

Witness testified in the presence of the charged inmate: ☑ Yes ☐ No If no, state reason:

Summary of Testimony:

Testimony was: ☐ Credited ☐ Rejected Reason:

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK ——————————————X

LEVAR T. HENRY

Plaintiff,

-against-

SECURITY CAPTAIN MICHEAL WILLIAMS, et. al,

Defendants.

——————————————————————————X

EXHIBIT

J

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(30)

Prison Health Services
Contracted by NYC Department of Health and Mental Hygiene

CERTIFICATION

I, Petrina S. Mariner, the Director of Medical Records/Materials Management of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, hereby certify that the record of the attached is in the custody of and is an accurate and complete record of the condition, act, transaction, occurrence or event of this program concerning:

Henry Levar
Name of Patient

3490721085
Book and Case Number

I further certify that this record was made in the regular course of business of this program and it is the regular course of business of this program to makes such records. The record was made at the time of the condition, act, transaction, occurrence or event recorded or within a reasonable time thereafter. The record contained herein is a certified reproduction of the record on file (In accordance with CPLR Section 2306)

2/22/11
Date

Petrina S. Mariner
Director of Medical Records/MM

DELEGATION OF AUTHORITY

I, Fazal M. Yussuff, Regional Director of Operations of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, certify that, Petrina Mariner, Director of Medical Records/Materials Management, of Prison Health Services, contracted by NYC Department of Health and Mental Hygiene, whose signature above is a responsible employee in this program. I hereby authorize her to certify records of this program as accurate and complete records of this program, such records having been made on the regular course of business of this program, such records having been made on the regular course of business of this program at the time of the condition, act, transaction, occurrence, or event recorded or within a reasonable time thereafter.

Fazal M. Yussuff, MPA
Regional Director of Operations, PHS

NYC Health
THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS & IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROBLEM LIST

Patient's Last Name	First Name
Henry	Levar

Book & Case Number	NYSID Number
349-07-21085	07839962Z

DOB 11/7/1977

ALLERGIES: NKA

CHRONIC MEDICAL PROBLEMS	DATE LISTED
abrasion mouth/ lips	11/17/2007
s/p fx left ankle	11/17/2007
razor bumps	5/17/2008
dental consult dd 8/29/08	9/10/2008
oral surgery	12/16/2008
b/l feet pain	12/23/2008
L. ankle injury	12/26/2008
Podiatry visit	2/9/2009
cavovarus foot	2/12/2009
Injury report:- s/p physical altercation	2/20/2009
Podiatry visit	2/20/2009
condyloma accuminatum Podofilox	2/25/2009
ANNUAL H & P	5/6/2009
dermatitis groin / bing	6/4/2009
Pain	9/14/2009
bing=seborrhea scalp	9/26/2009
retained root # 12	9/29/2009
C/O Back Pain	10/5/2009
DENTAL	10/8/2009
dental / oral surgery	10/20/2009
tooth pain	10/29/2009
Pain	11/12/2009
s/p Dental extraction	12/11/2009
Tinea pedis	12/11/2009
DENTAL	12/31/2009
Rhinitis	2/12/2010
Injury rep#: 743/ R/O Skull, R arm/ leg,& Ribs Fx	3/12/2010
Hospital Return S/P multiple trauma	3/13/2010
rt.lat. epicondylitis	3/22/2010
rt. lat. epicondylitis	4/29/2010
Pain	4/29/2010
Pain	4/29/2010
Pain	4/29/2010
Pain	4/29/2010
Dental Abscess	4/30/2010
retained roots	5/4/2010
rt.lat. epicondylitis	5/26/2010
rt. lateral epicondylitis	7/26/2010

PSYCHIATRIC DSM IV DIAGNOSIS	DATE LISTED

SUICIDE WATCH	DATE ON	DATE OFF

SUICIDE RISKS	DATE LISTED

(32)

Annual check up done	8/30/2010

INMATE HAS CONTRAINDICATIONS FOR

Category A (Chemical Agents):

Medically contraindicated if the patient has ☐ Asthma ☐ Chronic Obstructive Pulmonary Disease (COPD)

Category B (Stun Shield):

Medically contraindicated if the patient has ANY of the following conditions: **(Check All That Apply)**

☐ Pregnancy ☐ Hypertension ☐ Pace Maker ☐ Asthma ☐ Seizure ☐ Diabetes ☐ Cardiac Disease

☒ **NO CONTRAINDICATIONS**

Signature: **Arthur Louie** **Date:** **11/17/2007**

DATE PPD IMPLANTED	RESULT	DATE READ	INITIAL
11/17/2007	00mm	11/19/2007	jeanoj
6/23/2009	oomm neg	6/23/2009	mercurcm
2/1/2010	Late entry ppd read 2/4/10 00mm	2/5/2010	allenea

IMMUNIZATION	DATE

LABORATORY DATA	DATE ORDERED	RESULT
Dipstick	11/17/2007	WNL
PPD	11/17/2007	00mm
RPR	11/17/2007	Normal
STD Urine Screen	11/17/2007	
Dipstick	11/17/2007	
Chlamydia/GC Urine	11/17/2007	Normal
RPR	5/6/2009	Normal
PPD	6/23/2009	oomm neg
PPD	2/1/2010	Late entry ppd read 2/4/10 00mm
RPR	8/30/2010	Normal
HIV Rapid	9/1/2010	Sero-Negative

RADIOLOGY/TYPE	DATE ORDERED	DATE PERFORMED	RESULT
Extremity	12/26/2008	12/26/2008	Please disregard this x-ray request.
ANKLE 3 VIEWS BIL	12/26/2008	1/7/2009	normal study
Elbow Right Ap, Lateral	3/22/2010	3/26/2010	ABN per PA. Parks

FOLLOW-UP/CONSULTS	DATE ORDERED	CLINIC	FACILITY	DATE SEEN
Medical Followup - bumps in pubic	4/28/2008	Medical	OBCC	5/8/2008
Specialty - 5/08/08	5/12/2008	Dermatology	WF	
Specialty - 5/08/08	5/19/2008	Dermatology	WF	
Specialty - 5/08/08	5/28/2008	Dermatology	WF	
Specialty - 5/08/08	6/9/2008	Dermatology	WF	
Specialty - 6/25/2008	6/25/2008	Mental Health	AMKC	
Specialty - podiatry	12/10/2008	Podiatry	WF	
Specialty - 12/10/08	12/12/2008	Podiatry	WF	12/26/2008
Specialty - 12/26/08	12/29/2008	Podiatry	WF	
Specialty - 1/22/09-evaluate for genital warts	1/22/2009	Dermatology	WF	
Specialty - 1/30/09-evaluate for onychomycosis	1/30/2009	Podiatry	WF	2/9/2009
Specialty - 1/22/09-evaluate for genital warts	2/10/2009	Dermatology	WF	
Specialty - 2/09/09	2/10/2009	Orthopedic	WF	2/12/2009
Specialty - 2/09/09	2/11/2009	Podiatry	WF	
Specialty - 2/09/09 & 2/12/09	2/11/2009	Podiatry	WF	2/20/2009
Medical Followup - s/p phys. altercation - f/u "side" pain	2/20/2009	Medical	AMKC	2/23/2009
Specialty - 2/20/09	2/23/2009	Podiatry	WF	
Nursing Followup - update rpr/ ppd implant	3/10/2009	Abnormal Labs	AMKC	
Medical Followup - HX/PE	3/10/2009	Abnormal Labs	AMKC	

Specialty - 3/13/2009	3/13/2009	Mental Health	AMKC	
Medical Followup - HX/PE	3/19/2009	Abnormal Labs	AMKC	5/6/2009
Specialty - 2/20/09, 2/9/2009	3/24/2009	Podiatry	WF	
Nursing Followup - READ PPD	4/16/2009	Abnormal Labs	GRVC	
Nursing Followup - Implant ppd, rpr	6/2/2009	Abnormal Labs	GRVC	
Medical Followup - annual PE	6/3/2009	Medical	GRVC	
Nursing Followup - Implant ppd, rpr	6/9/2009	Abnormal Labs	GRVC	
Nursing Followup - READ PPD	6/11/2009	Abnormal Labs	GRVC	6/17/2009
Medical Followup - annual PE	6/15/2009	Medical	GRVC	6/25/2009
Nursing Followup - Implant ppd, rpr	6/17/2009	Abnormal Labs	GRVC	6/20/2009
Nursing Followup - ppd reading	6/20/2009	Abnormal Labs	GRVC	6/22/2009
Nursing Followup - oomm	6/23/2009	Abnormal Labs	GRVC	6/22/2009
Nursing Followup - ppdimplant	6/23/2009	Abnormal Labs	AMKC	2/1/2010
Specialty - toothache	8/19/2009	Dental Initial Exam	GRVC	
Specialty - not produced	9/4/2009	Dental Initial Exam	GRVC	9/14/2009
Specialty - ext.#12 root	9/14/2009	Dental Oral Surgery	GRVC	9/29/2009
Specialty - f/u	10/5/2009	Dental Initial Exam	GRVC	10/8/2009
Specialty - Exo#12	10/8/2009	Dental Oral Surgery	GRVC	10/20/2009
Nursing Followup - needs u/a and ppd implant	10/26/2009	Nursing	AMKC	
Medical Followup - needs annual physical and exam	10/26/2009	Medical	AMKC	11/17/2009
Specialty - 10/29/2009 refused 11/12	10/29/2009	Dental Initial Exam	AMKC	
Specialty - s/p dental extraction claims piece of bone is protuding	12/11/2009	Dental Initial Exam	AMKC	
Specialty - dental	1/13/2010	Dental Initial Exam	AMKC	
Specialty - S/p multiple trauma w negative CT scans of head and extremities. swelling / pain r elbow. Please evaluate	3/13/2010	Abnormal Labs	AMKC	
Specialty - 3/13/10	3/15/2010	Orthopedic	WF	3/22/2010
Specialty - 3/22/10	3/23/2010	Orthopedic	WF	4/29/2010
Specialty - tooth ach	3/26/2010	Dental Initial Exam	GRVC	
Specialty - severe toothace ermergency pt	4/30/2010	Dental Initial Exam	GRVC	4/30/2010
Specialty - EXT # 5 # 8 #9	4/30/2010	Dental Oral Surgery	GRVC	
Specialty - 4/29/10	4/30/2010	Orthopedic	WF	5/26/2010
Specialty - 4/29/10	4/30/2010	Rehab/Physical Therapy	WF	5/6/2010
Specialty - 5/6/10	5/7/2010	Rehab/Physical Therapy	WF	5/17/2010
Specialty - 5/17/10	5/18/2010	Rehab/Physical Therapy	WF	5/24/2010
Specialty - 5/24/10	5/25/2010	Rehab/Physical Therapy	WF	6/1/2010
Specialty - 5/26/10	5/27/2010	Orthopedic	WF	6/10/2010
Specialty - 6/1/10	6/2/2010	Rehab/Physical Therapy	WF	6/8/2010
Specialty - 6/10/10	6/11/2010	Orthopedic	WF	7/26/2010
Specialty - 6/8/10	6/11/2010	Rehab/Physical Therapy	WF	
Specialty - 6/8/10	6/16/2010	Rehab/Physical Therapy	WF	6/22/2010
Specialty - 6/22/10	6/23/2010	Rehab/Physical Therapy	WF	6/29/2010
Specialty - 6/29/10	6/30/2010	Rehab/Physical Therapy	WF	7/6/2010
Specialty - 7/6/10	7/7/2010	Rehab/Physical Therapy	WF	7/13/2010
Specialty - 7/13/10	7/14/2010	Rehab/Physical Therapy	WF	7/20/2010
Specialty - 7/20/10	7/21/2010	Rehab/Physical Therapy	WF	7/27/2010

Specialty - 7/26/10, 6/10/10	7/27/2010	Orthopedic	WF	
Specialty - 7/26/10 & 7/27/10	7/27/2010	Rehab/Physical Therapy	WF	8/3/2010
Specialty - 8/3/10	8/4/2010	Rehab/Physical Therapy	WF	8/10/2010
Specialty - 8/10/10	8/11/2010	Rehab/Physical Therapy	WF	8/17/2010
Specialty - 8/17/10	8/18/2010	Rehab/Physical Therapy	WF	8/24/2010
Medical Followup - annual physical	8/21/2010	Abnormal Labs	GRVC	8/30/2010
Specialty - 8/24/10	8/25/2010	Rehab/Physical Therapy	WF	8/31/2010
Nursing Followup - hiv test	8/26/2010	Nursing	GRVC	
Nursing Followup - hiv test	8/26/2010	Nursing	GRVC	
Nursing Followup - hiv testing	8/30/2010	Abnormal Labs	GRVC	9/1/2010
Specialty - 8/31/10	9/1/2010	Rehab/Physical Therapy	WF	9/7/2010
Specialty - 9/7/10	9/8/2010	Rehab/Physical Therapy	WF	
Specialty - 9/7/10	9/15/2010	Rehab/Physical Therapy	WF	

MEDICATION LIST

START DATE	MEDICATION	DATE DISCONTINUED
11/17/2007	Bacitracin - Ointment - 500UNIT/GM - qs top bid	12/1/2007
4/17/2008	Sebex - Shampoo - 2-2% - Wash scalp BIW	5/17/2008
5/17/2008	Cleocin - Solution - 1% - qs topically bid	5/27/2008
6/25/2008	Cleocin - Solution - 1% - Apply affected area bid	7/2/2008
8/26/2008	Sebulex - Shampoo - 2-2% - wash area qod	9/2/2008
8/29/2008	Ibuprofen - Tab - 400MG - 1 tab po bid	9/2/2008
8/29/2008	Micatin - Cream - 2% - qs top bid	9/12/2008
9/4/2008	Bacitracin - Ointment - 500UNIT/GM - apply to area top bid	9/9/2008
9/4/2008	Bacitracin - Ointment - 500UNIT/GM - apply to area top bid	9/9/2008
9/4/2008	Bacitracin - Ointment - 500UNIT/GM - apply to area top bid	9/9/2008
9/16/2008	Sebulex - Shampoo - 2-2% - wash area top qod	9/23/2008
12/5/2008	Podofilox - Solution - 0.5% - apply q12h x 3 dys; repet after 4 dys	12/17/2008
12/5/2008	Motrin - Tab - 400MG - 1 tab po bid	12/10/2008
12/10/2008	Tylenol - Tab - 325MG - 2 tabs po bid	12/15/2008
12/11/2008	Podofilox - Solution - 0.5% - apply top dailyx3 days, repeat after 4 days	12/22/2008
12/18/2008	Podofilox - Solution - 0.5% - apply topically qd x 3days, repeat after 4days	12/29/2008
12/24/2008	Naproxen - Tab - 500MG - 500mg po bid	
1/2/2009	Naprosyn - Tab - 500MG - po bid	1/7/2009
1/2/2009	Analgesic Balm - Ointment - 15-15% - top bid	1/16/2009
1/3/2009	Podofilox - Solution - 0.5% - apply qd top x3 days,repeat after 4 days	1/13/2009
1/16/2009	Podofilox - Solution - 0.5% - top affected area qd x7d	1/23/2009
1/22/2009	Podofilox - Solution - 0.5% - apply qd x 3 days and repeat after 4 days	1/25/2009
1/27/2009	Naprosyn - Tab - 500MG - po bid	2/1/2009
1/30/2009	Podofilox - Solution - 0.5% - apply qd x 3 days and repeat after 4 days	2/2/2009
2/6/2009	Podofilox - Solution - 0.5% - apply qd x3days	2/9/2009
2/9/2009	Miconazole - Cream - 2% - bid plantarly	4/10/2009
2/10/2009	Podofilox - Solution - 0.5% - top qd on M/W/F	2/24/2009
2/10/2009	Motrin - Tab - 400MG - 2 tabs po bid	2/15/2009
2/20/2009	Miconazole - Cream - 2% - bid plantarly	4/21/2009
2/23/2009	Ibuprofen - Tab - 400MG - TAKE 400MG PO BID	2/27/2009
2/24/2009	Maalox Plus - Suspension - 225-200-25MG/5ML - 30cc po bid	3/1/2009
2/25/2009	Podofilox - Solution - 0.5% - apply daily	
2/27/2009	Paroxetine HCl - Tab - 20MG - 20 mg po q hs	3/6/2009
3/10/2009	Paxil - Tab - 20MG - hs	3/17/2009
3/14/2009	Paxil - Tab - 20MG - 1 po qhs	3/21/2009
3/20/2009	Paxil - Tab - 20MG - qhs	4/3/2009
4/2/2009	Paxil - Tab - 30MG - 30mg/po/qhs	4/16/2009
4/16/2009	Paxil - Tab - 40MG - increased,40mg/po/qhs	4/30/2009
4/30/2009	Paxil - Tab - 40MG - 1 po qhs	5/14/2009
5/7/2009	Podofilox - Solution - 0.5% - QS TOP WART MON, WED FRI	6/6/2009
5/18/2009	Paxil - Tab - 40MG - 40mg/po/qhs	5/25/2009
5/26/2009	Paxil - Tab - 40MG - po qhs	5/31/2009
5/30/2009	Paxil - Tab - 40MG - 40mg/po/qhs	6/13/2009
6/4/2009	Lidex - Ointment - 0.05% - qs top bid	6/18/2009
6/14/2009	Paroxetine HCl - Tab - 40MG - 1 tab po qhs	6/28/2009
6/25/2009	Selsun - Shampoo - 2.5% - qs top to scalp biw	7/9/2009
6/25/2009	Miconazole - Cream - 2% - qs top plantarly bid	7/9/2009
6/27/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40 mg po qhs	7/11/2009

6/28/2009	Sebulex - Shampoo - 2-2% - top qd	7/12/2009
6/28/2009	Motrin - Tab - 400MG - 1 tab po bid	7/3/2009
7/9/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40mg po qhs	7/16/2009
7/9/2009	Risperdal M-TAB - Capsule - 1MG - hs	7/16/2009
7/15/2009	Risperdal M-TAB - Capsule - 1MG - 1 tab po qhs	7/29/2009
7/15/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40 mg po qhs	7/29/2009
7/28/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40 mg po qhs	8/11/2009
7/28/2009	Risperdal M-TAB - Capsule - 1MG - 1 tab po qhs	8/11/2009
8/1/2009	Sebulex - Shampoo - 2-2% - shamoo scalp biw	8/31/2009
8/1/2009	Micatin - Cream - 2% - top to feet bid	8/31/2009
8/11/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40 mg po qhs	8/25/2009
8/11/2009	Risperdal M-TAB - Capsule - 1MG - 1 tab po qhs	8/25/2009
8/19/2009	Motrin - Tab - 400MG - 1 tab po bic pc prn	8/22/2009
8/19/2009	Sebex - Shampoo - 2-2% - For shampoo tiw	9/18/2009
8/21/2009	Miconazole - Cream - 2% - qs top bid to feet	9/4/2009
8/21/2009	Dry Skin Lotion (MO/Bing Areas) - Lotion - - qs top bid	9/4/2009
8/25/2009	Risperdal M-TAB - Capsule - 1MG - 1 tab po qhs	8/30/2009
8/25/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40 mg po qhs	8/30/2009
8/30/2009	Miconazole - Cream - 2% - top bid	9/13/2009
8/31/2009	Risperdal M-TAB - Capsule - 1MG - po q hs	9/14/2009
8/31/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40mg po q hs	9/14/2009
9/1/2009	Peridex - Solution - 0.12% - 30 cc rinse mouth bid	9/15/2009
9/13/2009	Risperdal M-TAB - Capsule - 1MG - 1 tab po qhs	9/27/2009
9/13/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40 mg po qhs	9/27/2009
9/20/2009	Miconazole - Cream - 2% - top bid	10/4/2009
9/24/2009	Risperdal M-TAB - Capsule - 1MG - One Cap PO qhs	9/29/2009
9/24/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40mg PO qhs	10/8/2009
9/24/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40mg PO qhs	9/29/2009
9/24/2009	Risperdal M-TAB - Capsule - 1MG - One Cap PO qhs	10/8/2009
9/26/2009	Sebulex - Shampoo - 2-2% - shampoo 2 x aweek	10/26/2009
9/29/2009	Risperdal M-TAB - Capsule - 1MG - hs	10/13/2009
9/29/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40mg po qhs	10/13/2009
10/5/2009	Naprosyn - Tab - 500MG - 1 tab po bid/prn	10/12/2009
10/14/2009	Paroxetine HCl - Suspension - 10MG/5ML - 40 mg po qhs	10/27/2009
10/14/2009	Risperdal M-TAB - Capsule - 1MG - 1 tab po qhs	10/27/2009
10/20/2009	Ibuprofen - Tab - 400MG - 2 tabs po bid prn pain	10/25/2009
10/27/2009	Paxil - Tab - 40MG - 40mg/po/qhs	11/25/2009
10/27/2009	Risperdal - Tab - 1MG - 1mg/po/qhs	11/25/2009
10/30/2009	Motrin - Tab - 400MG - 400mg po bid	
10/30/2009	Peridex - Solution - 0.12% - rinse 15ml po qAM & q PM	
11/25/2009	Risperdal - Tab - 1MG - 1 hs	11/30/2009
11/25/2009	Paxil - Tab - 40MG - 1 hs	11/30/2009
11/30/2009	Risperdal - Tab - 1MG - 1mg/po/qhs	12/14/2009
11/30/2009	Paxil - Tab - 40MG - 40mg/po/qhs	12/14/2009
12/11/2009	Miconazole - Cream - 2% - QS topically BID	12/26/2009
12/15/2009	Risperdal - Tab - 1MG - hs	1/11/2010
12/15/2009	Paxil - Tab - 40MG - hs	1/11/2010
12/30/2009	Tylenol - Tab - 325MG - 2 tabs po bid/prn	1/4/2010
12/30/2009	Zithromax - Tab - 250MG - 500mg po stat; 1 tab po daily	1/3/2010
12/30/2009	Chlor-Trimeton - Tab - 4MG - 1 tab po tid	1/4/2010

1/11/2010	Risperdal - Tab - 1MG - hs	2/8/2010
1/11/2010	Paxil - Tab - 40MG - hs	2/8/2010
2/8/2010	Risperdal - Tab - 1MG - 1 MG PO QHS	2/22/2010
2/8/2010	Paxil - Tab - 40MG - 40 MG PO QHS	2/22/2010
2/12/2010	Guaifenesin - Tab - 200MG - 200 mgrs PO BID	2/16/2010
2/12/2010	Sudafed - Tab - 30MG - 60 mgrs PO BID	2/16/2010
2/19/2010	Ocean Nasal Spray - Solution - 0.65% - 1 spray in nostril bid	2/24/2010
2/19/2010	Tylenol - Tab - 325MG - 2 tab po bid	2/24/2010
2/22/2010	Paxil - Tab - 40MG - 40 MG PO QHS	3/8/2010
2/22/2010	Risperdal - Tab - 1MG - 1 MG PO QHS	3/8/2010
3/8/2010	Paxil - Tab - 40MG - 1 hs	4/5/2010
3/8/2010	Risperdal - Tab - 1MG - 1 hs	4/5/2010
3/13/2010	Motrin - Tab - 400MG - 1 tab po bid	
3/13/2010	Tylenol/Codeine #3 - Tab - 300-30MG - 2 tabs po bid prn	
3/20/2010	Motrin - Tab - 400MG - 1 tab bid,pc	3/24/2010
3/26/2010	Tylenol/Codeine #3 - Tab - 300-30MG - 2 tab po bid prn	3/30/2010
4/5/2010	Paxil - Tab - 40MG - hs	5/3/2010
4/5/2010	Risperdal - Tab - 1MG - hs	5/3/2010
4/29/2010	Tylenol/Codeine #3 - Tab - 300-30MG - 1 bid	5/4/2010
5/3/2010	Motrin - Tab - 400MG - 1 tab po bid	5/8/2010
5/3/2010	Sebex - Shampoo - 2-2% - apply to affected scalp TIW	5/17/2010
5/3/2010	Acetaminophen/Codeine #3 - Tab - 300-30MG - 1 tab po bid prn	5/6/2010
5/4/2010	Paroxetine HCl - Tab - 40MG - 40 mg po qhs	5/18/2010
5/4/2010	Risperidone - Tab - 1MG - 1 mg po qhs	5/3/2010
5/17/2010	Paxil - Tab - 40MG - hs	5/20/2010
5/21/2010	Paroxetine HCl - Tab - 40MG - 40 mg po qhs	6/16/2010
6/16/2010	Paxil - Tab - 40MG - PO Q AM	7/14/2010
7/14/2010	Paxil - Tab - 40MG - qam (bridge order)	7/19/2010
7/19/2010	Paxil - Tab - 40MG - po qam	7/23/2010
7/23/2010	Paxil - Tab - 40MG - 1 tab po am only	8/6/2010
8/6/2010	Paxil - Tab - 40MG - PO Q AM	9/4/2010
8/9/2010	Selsun - Shampoo - 2.5% - QS TO AREA QD	8/30/2010
8/9/2010	Ibuprofen - Tab - 400MG - 2 TABS PO BID	8/13/2010
9/5/2010	Paroxetine HCl - Tab - 40MG - 40 mg po qam	10/3/2010

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

Henry Levar
349-07-21085

EVERY ENTRY MUST BE DATED AND SIGNED

DATE	OBSERVATIONS
12.5.08	NO CHART
C98	PANOTE S/C.
4.50p	Pt c/o foot pain from wearing sneakers. Pt also c/o genital wart in pubic area.
	VITALS: B/P: 113/64 P: 65 R: 16 T: 97°
	Pt. appears AAA O×3 in NAD
	FEET: ∅ tenderness, ∅ swelling ∅ deformity
	PUBIC AREA: ~~Genital~~ wart on pubic area
	MP. Foot pain / Genital wart
	Motrin 600mg PO TID PRN ; Podofilox 0.5% PRN F/U PRN

Terry Grimaldo PA

LIONEL PESQUES, M.D.

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(40)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

12/10/2008
6:26:44 PM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**AMKC/QUAD-U10**	Dosage:	**325MG**
Drug:	**Tylenol**				
Form:	**Tab**	SIG:	**2 tabs po bid**		
Reason:	**Other - pain**	Start:	**12/10/2008**	Duration:	**5 days**
Written by:	**Victoria Brightman, PA - Physician Assistant**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC: _____

(41)

1/7/09

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

RECEIVED DEC 11 2008

Leave blank for hospital use

Routine

Jean Richard, MD

Patients' Name HENRY Henry Lerar DOB 12/7/77

FROM CJS , 3491072085
Correctional institution Inmate no.

Referred to Podiatry Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

c/o [illegible] ankle [illegible] and [illegible] to see [illegible]

Diagnosis, treatment and medications by C.H.S.:

noted pes planus c̄ depressed MPJ area. Please evaluate [illegible]

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

no DM/HTN.

Request:

Date 12/10/08 Referring Physician [signature] Phone ______ Approved ______

Consultation, findings and recommendations:

(+) NVSI (B/L); (+) tenderness on palpation lateral (L) ankle; (+) mild tenderness on ROM; (+) mild edema; ∅ erythema

→ Pt. relates h/o ankle fx → (L); '89 & '03

→ Application of ACE bandage (L) ankle

→ Rx: X-rays of (L) ankle

→ Due to Pt's foot & ankle condition, the pt. may be allowed to wear his supportive shoes for a period of 30 days per discretion of the facility

Date 12/26/08 Physician [signature]

Reminder: Fully Complete the Problem List

(42)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry Levar DOB 11/7/77

FROM CYS, 3491573105 — Correctional institution / Inmate no.

Referred to Podiatry Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Chief complaint or findings:

c/o plantar pain on ambulation and inability to see foot doctor

Diagnosis, treatment and medications by C.H.S.:

noted pes planus & depressed arch. Please evaluate and tx.

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

no DM/HTN.

Request:

Date 12/11/08 Referring Physician [signature] Phone ______ Approved ______

Consultation, findings and recommendations:

Date ______ Physician ______

Reminder: Fully Complete the Problem List

(43)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Jesse B&C #: 342072185

Date: of Appointment: 12/26/08 Facility: SMCC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☑ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☑ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Medication order(s) written:	☐ Yes	☑ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☑ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☑ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. X-rays: (L) Ankle 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ Signature

Rafael Tabari, DPM
Podiatry
Provider Stamp

12/26/08
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(44)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Henry Lever
349-07-21085

DATE	OBSERVATIONS
2/23/08 AMKC	S/C S: Pt c/o foot pain S/P B/L foot fx. 2003 having intermittent discomfort/pain on ambulation V/S: 98/60 64 16 97f Alert + oriented x3 NAD Stable. HEENT - PERRL Cardio - RRR Lung CTA B/L Abd +BS Soft NT. Ext - left foot ⊖erythema ⊖edema ⊖tenderness - Right " ⊖erythema ⊖edema ⊖tenderness. A/ B/L foot Pain Plan: Naproxen. 500mg po bid x 4days. Cooper PAC LIONEL DESROCHES, M.D.

REMINDER: FULLY COMPLETE THE PROBLEM LIST

45

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

12/23/2008
5:16:01 PM

Name: Henry, Levar
DOB: 11/7/1977
Drug: Naproxen
Form: Tab
Reason: Other - pain
Written by: Iceyleen Cooper, PA - Physician Assistant
Approved by:
Allergies: NKA

Book & Case: 349-07-21085
Site/Housing: AMKC/QUAD-U10

SIG: 500mg po bid
Start: 12/24/2008

NYSID: 7839962Z

Dosage: 500MG

Duration: 4 days

Pharm: _____

LIONEL DESROCHES, M.D.

DC:

(46)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

1/2/2009
9:22:11 AM

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	7839962Z
DOB:	11/7/1977	Site/Housing:	AMKC/QUAD-U10		
Drug:	Naprosyn			Dosage:	500MG
Form:	Tab	SIG:	po bid		
Reason:	Other - pain	Start:	1/2/2009	Duration:	5 days
Written by:	Terry Ann Gravesande, PA - Physician Assistant				
Approved by:				Pharm:	_____
Allergies:	NKA				

DC:

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	7839962Z
DOB:	11/7/1977	Site/Housing:	AMKC/QUAD-U10		
~~Drug:~~	~~Analgesic Balm~~			~~Dosage:~~	~~15-15%~~
Form:	Ointment	SIG:	top bid		
Reason:	Other - pain	Start:	1/2/2009	Duration:	14 days
Written by:	Terry Ann Gravesande, PA - Physician Assistant				
Approved by:				Pharm:	_____
Allergies:	NKA				

DC:

---

(47) 1/9

F/u 2 wks

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

RECEIVED
DEC 29 2008

1/9/09 p>v

Patients' Name Henry, Levar DOB 11/7/77

FROM AMKC / 349072085
Correctional institution Inmate no.

Referred to Podiatry Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings: S/P (L) ankle trauma

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request: F/u W/ x-rays.

Rafael Tabari, DPM
Podiatry

Date 12/26/08 Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Refused 1/9/09

Date _____ Physician _____

NYC Health

THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

West Facility
16-06 Hazen Street
East Elmhurst, NY 11370
Phone:
Fax:

Henry, Levar 349-072-1085

Name:	Levar Henry	**Exam Date:**	
Patient ID:	7839962Z	**Exam:**	ANKLE, AP & LATERAL
DOB:	11/7/1977	**Reason:**	-
Phone:		**Referrer:**	Anna M. Kross Center AMKC
Acc#:	5410	**2nd Referrer:**	Jean Richard
		3rd Referrer:	

Results

STUDY: LEFT ANKLE X-RAY

CLINICAL HISTORY:

TECHNIQUE: AP, lateral, and oblique views.

FINDINGS: AP, lateral, and oblique views were obtained of the left ankle reveal the ankle mortise to be intact. There is no fracture or dislocation. No heel spurs are seen. Subtalar joint is intact.

IMPRESSION:

Normal study.

Report Electronically Signed by: Jack Baldasar
Report Signed on: 1/5/2009 9:14 AM

Pt. Name:	Levar Henry	Exam:	ANKLE, AP & LATERAL
Patient ID:	7839962Z	Acc:	5410
Completed Date:	1/1/1900 12:00:00 AM	Interpreting Rad:	Jack Baldasar
Transcribed By:	Raj Dharmaraj	Dictated Date:	1/4/2009
Transcribed Date:	1/5/2009 11:34 AM	Finalized Date:	1/5/2009 9:14 AM

(49)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE + ENT, Lavar

Leave blank for hospital use

Patients' Name Lavar Henry DOB 11/7/77

FROM ANKC 34A072085
Correctional institution Inmate no.

Referred to Podiatry Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.: Evaluate for nail

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings: Swelling + Pain of onychomycosis

Request:

Date 1/30/09 Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

Reminder: Fully Complete the Problem List

5014 (Rev. 5/04)

(50)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Levay B&C #: 349072185

Date: of Appointment: 12/9/09 Facility: HMCC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☒ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. ONTHOPEDIC CONSULTATION 4. WHIRLPOOL
2. _____ 5. _____
3. _____ 6. _____

_____ Signature

Allan Goldberg, DPM Provider Stamp

12/9/09 Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

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YELLOW COPY TO *UM DEPARTMENT*

(51)

2/27

CONSULTATION REQUEST

RECEIVED FEB 2009

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

HENRY

Patients' Name Lavon Henry DOB 11/7/77

FROM ~~Podiatry~~ AMKC / 3490721085
Correctional institution Inmate no.

Referred to Podiatry Ward / Clinic

Hospital / Clinic no.

Leave blank for hospital use

Routine

Jean Richard, MD

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Evaluate for ankle swelling & pain & onychomycosis

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Consult Review
On Island Specialty Clinic
☑ No Action Needed
☐ See Progress Note
Signature
Curt Walker, RPA 2-10-09
Name Stamp **Date**

Request:

DESROCHES MD

Date 1/30/09 Referring Physician ______ Phone ______ Approved ______

Consultation, findings and recommendations:
(B) FOOT PAIN → PT PRESENTS IN FLIP-FLOPS & HAS DIFFICULTY WALKING
(+) S/P Fx (L) ANKLE (-) ANY ABRASIONS TO MEDS
PEDAL PULSES PALPABLE (B)
Hx Fx (L) ANKLE → L > R FOOT PAIN → ORTHOPEDIC CONSULTATION WRITTEN
SUGGEST MEDICAL F/U
KEEP FEET DRY
NO X-RAYS ARE AVAILABLE FOR REVIEW
RE-MINERALIZE LI UREA 6 PROTOCOL BID x 2 MO (TINEA)

(RTC 3/23/09)

Date 2/19/09 Physician ______

CHS 5014 (Rev. 5/04) Ellen Goldberg, DPM

Reminder: Fully Complete the Problem List

(52)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

2/9/2009
1:43:50 PM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**AMKC/QUAD-U10**		
Drug:	**Miconazole**			Dosage:	**2%**
Form:	**Cream**	SIG:	**bid plantarly**		
Reason:	**Other - tinea pedis**	Start:	**2/9/2009**	Duration:	**60 days**
Written by:	**Allan Goldberg, Podiatrist**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC:

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND **SIGNED**

Henry, Levar
3490720?5

DATE	OBSERVATIONS
	8/c
10/04/08	Pt c/o feeling stressed out, denies suicidal
OBZU	or homicidal
3:57(P)	O: Alert in NAD
	A/P
	1) h/o Depression
	— refer to MH
	Gregory Celestin, PA
	Z. Ghom, MD
2.10.09	NOTE RAN S/C.
CSY	Pt request renewal of pain meds
12:45 pm	for Lt ankle pain S/P surgery. Pt had x-ray and was seen by Podiatry.
	Pt. appears AA&O x3 in NAD
	Vitals: B/P: 106/62 P: 64 R: 16 T: 97.8
	Lt. ankle: ⊘ swelling, ⊘ tenderness,
	FROM ⊄ pain
	A/P: Lt ankle pain
	Motrin 800mg, Ankle brace
	Terry Gravesande, RPA-C
	Laali Ali, MD

CHS 288 (Rev. 3/05)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(54)

P, H 2/12

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name HENRY, LEVAN DOB 11/1/77

FROM AMKC, 349-07-21085
Correctional institution / Inmate no.

Referred to ORTHOPEDICS Ward / Clinic

Hospital / Clinic no.

Leave blank for hospital use

URGENT

Chief complaint or findings:

S/P (L) ANKLE FRACTURE C DIFFICULTY WALKING

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

FOR EVALUATION

Date 2/9/09 Referring Physician Allan Goldberg, DPM Phone Approved

Consultation, findings and recommendations: cavo varus foot. He states fx LT ankle 1989 & 2003

X-ray - Mortise intact. No fx ankle.

Dx - Problem 2° to cavorus foot.

This is a podiatric problem

Rx: Please send back to podiatrist. NOT orthopedic.

Date 2/11/09 Physician [signature] MD

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Pr... Lester Lieberman, MD

(55)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: HENRY First Name: LEVAR B&C #: 349-071085

Date: of Appointment: 2/12/09 Facility: A.M.K.C.

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☑ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☑ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☑ No	☐ N/A
Problem list in RIIS updated:	☑ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☑ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☑ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. Podiatry
2.
3.
4.
5.
6.

L Lieberman MD — Signature

Lester Lieberman, MD — Provider Stamp

2/12/09 — Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(56)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Levar B&C #: 349072085

Date: of Appointment: 2/20/09 Facility: Annex

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☑ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☑ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☑ 6 weeks	☐ Other:_____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ Signature

Allan Goldberg, DPM
Provider Stamp

2/26/09
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

57

2/12

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Leave blank for hospital use

URGENT

Patients' Name HENRY, LUJAN DOB 1/1/71

FROM AMKC , 349-07-21085
Correctional institution Inmate no.

Referred to ORTHOPEDICS Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

S/P ⊕ ANKLE FRACTURE c DIFFICULTY WALKING

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

For evaluation

Date 2/9/09 Referring Physician Allan Goldberg, DPM Phone Approved

Consultation, findings and recommendations: Cavovarus foot. He states he [illegible] surg. 1999 + 2003

x-ray - Hardware intact. No fx [illegible].

Imp - Problem 2° to cavovarus foot

This a podiatric problem.

Plan Please send back to Podiatrist.

NOT orthopedic.

Date 2/11/09 Physician [illegible] MD

Reminder: Fully Complete the Problem List

(58)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients Name Hurley, Luther DOB 1/7/77

FROM AMKC, 4407721085
Correctional institution Inmate no.

Referred to Podiatry Ward / Clinic

Hospital W.F / Clinic no.

Leave blank for hospital use

Rovini

Chief complaint or findings:

NOT ankle problem.
He has a cavus high foot
+ slight valgus [illegible]

Diagnosis, treatment and medications by C.H.S.:

Rx. Ankle x-ray - Neg.
[illegible] a long time ago.

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

[illegible]

2-23-05

Request:

Date 2/17/09 Referring Physician [signature] MD Phone Approved

Consultation, findings and recommendations:

Ⓡ foot pain in [illegible] [illegible] issued footwear → [illegible] work boots
[illegible] [illegible] to [illegible]
[illegible] pulses palpable Ⓑ
[illegible] [illegible] [illegible]
[illegible] [illegible] → [illegible]
[illegible] [illegible] [illegible] of [illegible] [illegible] [illegible] Ⓑ
[illegible] [illegible] Ⓑ [illegible] [illegible] [illegible] of [illegible]
[illegible] [illegible] [illegible]

(Mc 4.3.09)

Date 2/20/09 Physician [signature]

Reminder: Fully Complete the Problem List

59

RECEIVED
FEB 23 2009

CONSULTATION REQUEST 4/3/09

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use
Fm 6 WEEKS

Patients' Name HENRY LEVAN DOB 11/7/77

FROM AMKC 349-07-21085
Correctional institution Inmate no.

Referred to PODIATRY Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Fm DYSTROPHIC NAILS, PLANTAR TINEA, USE OF HOUSE BOOTS (CAUSING FOOT & ANKLE STRAIN ⑫ ⑬)

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

FOR EVALUATION

Date 2/20/09 Referring Physician Allan Goldberg, DPM Phone Approved

Consultation, findings and recommendations:

NIP ON 3/23/09 = RIS

NIP ON 3/27/09

Date Physician

Reminder: Fully Complete the Problem List

CHS 5014 (Rev. 5/04)

(60)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

2/20/2009
11:53:59 AM

Name: **Henry, Levar**
DOB: **11/7/1977**
Drug: **Miconazole**
Form: **Cream**
Reason: **Other - tinea pedis**
Written by: **Allan Goldberg, Podiatrist**
Approved by:
Allergies: **NKA**

Book & Case: **349-07-21085**
Site/Housing: **AMKC/QUAD-U10**
SIG: **bid plantarly**
Start: **2/20/2009**

NYSID: **7839962Z**
Dosage: **2%**
Duration: **60 days**
Pharm: _____

DC: _____

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name Lavon Henry DOB 1/3/77

FROM [redacted] AMKC / 3415721055
Correctional institution Inmate no.

Referred to Podiatry Ward / Clinic

Hospital / Clinic no.

Leave blank for hospital use

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Evaluate for ankle swelling * Pain & onychomycosis

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date 1/30/07 Referring Physician [signature] Phone ______ Approved ______

Consultation, findings and recommendations:

Date ______ Physician ______

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

DOCM 6C (62)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

Henry, Hevar
349 07 21085

EVERY ENTRY MUST BE DATED AND **SIGNED**

DATE	OBSERVATIONS
2.24.09 C98	NO CHART PA NOTE S/C
2.07p	Pt c/o upset stomach & vomiting x2 times today. Pt states that it started after breakfast this morning. Pt denies diarrhea. Pt enquire of boots permit that he was told to pick up at clinic after seeing Podiatrist. VITALS: BP: 100/60 P: 64 R: 16 T: 97.6 Pt appears AAO x3 in NAD CHEST: CTA HEART: S1 S2 Reg, RRR ABDOMEN: +BS, soft, NT A/P: Dyspepsia / Boots Permit. Maalox 30 c.c. Will refer to Dr Richards for Boots permit

Terry Gravesande, RPA-C
Reviewed 2/24/09

CHS 288 (Rev. 3/05)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(63)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

Henry Lever
J490720685

EVERY ENTRY MUST BE DATED AND **SIGNED**

DATE	OBSERVATIONS
1.27.05	NO CHART
CGY	PA NOTE S/C
11.20 AM	Pt request renewal of pain meds for Lt ankle s/p fracture
	~~V/S~~ VS: B/P: 110/70 P: 64 R: 16 T: 97.6
	Pt. appears AAOx3
	Ankle: ↓ swelling, ↓ tenderness FROM before.
	MP: Lt. ankle pain. Naproxen 500mg
	Terry Graves, P.A.
	Laali Ali, MD

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(64)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

1/27/2009
11:23:53 AM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**AMKC/QUAD-U10**		
Drug:	**Naprosyn**			Dosage:	**500MG**
Form:	**Tab**	SIG:	**po bid**		
Reason:	**Other - pain**	Start:	**1/27/2009**	Duration:	**5 days**
Written by:	**Terry Ann Gravesande, PA - Physician Assistant**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC: _____

(65)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND **SIGNED**

HENRY LAWAR
3140721085
R 6 L

DATE	OBSERVATIONS
3/02/09 0915 10:35 PM	no chart available Sick call C/O Pain in Left ankle S/P Injury. Pt is requesting renewal of Pain meds. T98.2 B/P 90/60 P70 R16 A/P: Pain in Left ankle Renewal of meds Bystolin 400 mg PO BID X 4 days Sylvan Sabal Sylvan Sabal, P.A.C

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(66)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

HENRY LEVAR
349-07-210.8S

EVERY ENTRY MUST BE DATED AND **SIGNED**

DATE	OBSERVATIONS
08/06/07 C45	Patient is stable, brought to Clinic because he want boots. PE Alert Cooperative V.S BP 112/62 P70 Neck Supple Lung Clear No Rales Heart Regular Rhythm Nerve No deficit Extremities: Left Ankle ROM perfect Strength Perfect Completely Normal Exam Ass: Normal left Ankle X Ray done 01/04/07 left Ankle Normal No support Boots Necessary J. RICHARDS PA

CHS 288 (Rev. 3/05)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(67)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Levar B&C #: 349074085

Date: of Appointment: 3/27/09 Facility: AMEC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☑ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Allan Goldberg, DPM

Signature Provider Stamp Date 5/27/09

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Provider will complete Section C

(68)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

8/21/2009
2:29:44 PM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**GRVC/13A**		
Drug:	**Dry Skin Lotion (MO/Bing Areas)**			Dosage:	
Form:	**Lotion**	SIG:	**qs top bid**		
Reason:	**Other - dry skin - bing**	Start:	**8/21/2009**	Duration:	**14 days**
Written by:	**Nicholas Pantea, PA - Physician Assistant**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC:

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**GRVC/13A**		
Drug:	**Miconazole**			Dosage:	**2%**
Form:	**Cream**	SIG:	**qs top bid to feet**		
Reason:	**Other - tinea pedis**	Start:	**8/21/2009**	Duration:	**14 days**
Written by:	**Nicholas Pantea, PA - Physician Assistant**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC:

(69)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

12/11/2009
10:09:42 AM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**AMKC/QUAD-U6**		
Drug:	**Miconazole**			Dosage:	**2%**
Form:	**Cream**	SIG:	**QS topically BID**		
Reason:	**Other - Tinea pedis**	Start:	**12/11/2009**	Duration:	**15 days**
Written by:	**Franklin Mejia, Physician**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC: _____

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

Henry Levar
J9907210S5

EVERY ENTRY MUST BE DATED AND **SIGNED**

DATE	OBSERVATIONS
12.09	NO CHART
C9J	PA NOTE S/C;
	Pt s/p Lt ankle fracture 2003 c/o pain of Lt. ankle. Pt had x-rays done and was seen by Podiatry.
	VitKs: B/P: 100/60 P: 64 R: 16 T: 97.5
	Pt. appears AA & O x 3 in NAD
	Lt foot: Mild tenderness of lateral Metatarsal area, ϕ swelling
	A/P: Lt foot pain:
	Naprosyn 500mg.
	Analgesic Balm.
	Terry Gravesande, PA
	L. ALI MD

REMINDER: FULLY COMPLETE THE PROBLEM LIST

6 70

CORRECTION DEPARTMENT
CITY OF NEW YORK

445/10

INJURY TO INMATE REPORT

Page 1 of 2 Pages | Form: #167R-A Rev.: 01/31/08 Ref.: Dir. #4516R-A

INSTRUCTIONS: Original Report to Security, One copy to Clinic Lock Box, One Copy to Inmate Medical File.

Command:	Date:	COD/UOF #:	Injury #:
AMKC	3/12/10	445/10	723

TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT CLEARLY).

Inmate Name (Last Name, First Name): HENRY, LEVAR

Location:	Work:	NYSID #:	Book & Case/Sent #:
Q L 10 (Tier)		T839962Z	3490721085

Details: ON MARCH 12, 2010 AT APPROX. 1750 HRS. IN QUAD LOWER 10 (TIER) INMATE HENRY, LEVAR 3490721085/T839962Z (CELL # 15) WAS INVOLVED IN A USE OF FORCE WITH DOC STAFF.

Supervisor Notified (Print Last Name, First Name, Rank, Shield #):	Date:	Time:
Gamble, Capt. #88	3/12/10	Approx. 1750 Hrs.

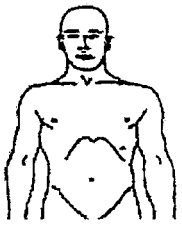
Employee: I [X] (Did) [ ] (Did Not) Witness This Injury.	Employee Signature:	Rank/Title:	Shield/ID#:
L. Arias	L. Arias	C.O	17955

TO BE COMPLETED BY MEDICAL STAFF ONLY - (PLEASE PRINT CLEARLY)

Date of Injury: MAR 12 2010	Reported for Medical Attention: Date MAR 12 2010 2215 Hrs.	Inmate Refused Medical Attention: [ ] Yes [X] No	Visible Injuries: [ ] Yes [X] No

Nature of Injury and Cause:
NO VISIBLE INJURIES NOTICED HOWEVER PATIENT C/O: RIGHT HEAD/TEMPORAL AREA, @ CHEST/RIB, @ ELBOW, @ HAND, & @ KNEE PAIN WITH NO SIGNIFICANT BRUISES, NOR SWELLING.

Medical Staff Must Note Location of Injury:



(72)

NYC Department of Health a[illegible]ental Hygiene

Hospital Transfer Form

Please use ball point pen and print legibly.

Referring DOC Facility: AMKC / C-95

Name of referring MD PROVILON, Pierre C. RPA-C
(Please Print) 718-546-3939

Hospital Run: ☐ EMS ☐ DOC: ☐ 3 hr. MD Phone#

Date: MAR 12 2010 Time: 10:35 AM/PM

Referred to: ☐ KCHC ☑ Elmhurst ☐ Bellevue

☐ Other:

Patient Name: HENRY, LEVAR

B&C #: 349-07-21685 DOB: 11-07-77
(Please Print)

Contact Urgicare if you have questions: **Beeper# 917-949-1234**
Phone# 718-546-4333

BP= 104/74, P=72, RR=18
T= 98.1

COMPLAINT: C/O (B) HEAD/TEMPORAL AREA, (B) LOWER CHEST, (B) ELBOW, (B) WRIST, & (B) KNEE PAIN DUE TO ASSAULT x 2 HR. PTA

PMH: MH, NKMD DEPRESSION

MEDS: RISPERDAL 1 mg, PO, HS
PAXIL 40 mg, PO, HS

Allergies: NKA

PE: (B) HEAD/TEMPORAL AREA, (B) lower chest, (B) ELBOW, (B) HAND & (B) KNEE tenderness

Studies/Labs: TM's intact.

Tx@RI: Multiple HEAD, Chest, (B) arm & leg contusions R/O SKULL, (B) ANKLE, RIBS, & (B) LEG fxs.

Significant ED findings/studies: HCT negative, R. elbow & R. knee

- Patient should follow up c ortho for R. elbow pain

Dx - negative for acute fx

Patient stable, all studies negative, patient can be discharge to Rikers

Discharge Dx: Multiple Contusions

Recommended FU:

motrin 800mg q 6 hrs
2 tabs Percocet 5/325 q 4 PRN

Fax completed form to Urgicare Center @ time of discharge - 718-546-4382

Physician Name (print) Vinant Reddy Signature: V. Reddy, MD Date: 3/13/10

Phone # 718. 334. 3054

CONTACT URGICARE IF YOU HAVE QUESTIONS / INFORMATION.

FOR BOROUGH HOUSES CONTACT REFERRING PRACTITIONER (ABOVE).

BEEPER #: 917-949-1234
PHONE #: 718-546-4333

(75)

Elmhurst
HOSPITAL CENTER
79-01 Broadway, Elmhurst, NY 11373
(718) 334-4000

New York City
Health and Hospitals
Corporation
Affiliated with
Mt. Sinai School of Medicine

Patient: Henry, Levar
Physician: David S. Cherkas, MD

MR#: 2886097
Acct #: 2886097-1
DOB: 11/7/1977

General Emergency Department Discharge Instructions / Medication Reconciliation

This form provides you with information about the care you received in our Emergency Department and instructions about caring for yourself after you leave the Emergency Department. If you have further questions concerning this visit contact the Adult ED at 718-334-3054 or contact Pediatric ED at 718-334-3000. Please keep this form and bring it with you should you need additional treatment. If your symptoms become worse or you are not improving as expected and you are unable to reach your usual health care provider, or get to your follow-up appointment, you should return to the Emergency Department immediately. We are available 24 hours a day.

You were treated in the Emergency Department by:

David S. Cherkas, MD 03/13/10

Vincent Roddy, MD 03/13/10

Your diagnosis is
Main Diagnosis: Contusion - multiple sites
Other: Second Diagnosis:
Other: Third Diagnosis:

What to do:

- Follow the instructions on the additional sheets you were given:
-
- Take this sheet with you when you go to your follow-up visit.
- If you have a problem arranging the follow-up visit, contact the Adult ED at 718-334-3054 or contact Pediatric ED at 718-334-3000.
- If on additional review and interpretation of your tests a change in diagnosis or treatment is needed we will attempt to contact you. It is critical that we have a current phone number for you.
- Some results, including cultures, may not be available for up to 48 hours. The Emergency Department will attempt to contact you if the results require a change in your treatment.

Additional information or instructions:

(74)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

SPECIALTY CLINIC / HOSPITAL RETURN TO GENERAL POPULATION

(For Patients Returning to Infirmary, Complete the Infirmary Return Form)

PATIENT'S LAST NAME	FIRST NAME	NYSID NUMBER
Henry	Levar	7839962Z

BOOK & CASE NUMBER	TIME	FACILITY	DOB
349-07-21085	8:43 ☒ AM ☐ PM	AMKC	11/16/2007

PATIENT WAS DISCHARGED ON 3/13/10 **FROM:** Elmhurst - ER

☐ **SPECIALTY CLINIC:** _____
(NAME OF SPECIALTY CLINIC)

☐ **HOSPITAL:** _____ HOSPITALIZATION DATES: __/__/__ TO __/__/__
(NAME OF HOSPITAL)

☐ **CHART REVIEW ONLY**

SUBJECTIVE:

- Paperwork Received from Specialist/Hospital? ☑ YES ☐ NO
- Recommendation Understood/Legible? ☑ YES ☐ NO
  - If NO, to either question, attempts made to contact specialist? ☐ YES ☐ NO
  - Attempts Successful? ☐ YES ☐ NO

If NO, refer to HAS or SMD for further attempts. If successful, document disposition, including contact person:

PHYSICAL EXAMINATION (If Indicated):

N/A

CONSULTANT'S RECOMMENDATIONS / DISCHARGE INSTRUCTIONS: ☐ NONE

(1) Observation ☑ DONE ☐ NO
(2) Ortho F/U ☑ DONE ☐ NO
(3) Anti inflamatory ☑ DONE ☐ NO
(4) Pain management ☑ DONE ☐ NO
(5) _____ ☐ DONE ☐ NO

ALL OF THE CONSULTANT'S RECOMMENDATIONS WILL BE FOLLOWED: ☐ YES ☐ NO If NO, explain why and consult SMD

SECOND OPINION REQUESTED BY PATIENT: ☐ YES ☑ NO

FACILITY CLINIC FOLLOW-UP INDICATED: ☑ YES ☐ NO Date: __/__/__

PATIENT EDUCATION (Discussed with Patient follow-up care, medication compliance/side effects): ☐ YES ☐ NO

PROBLEM LIST HAS BEEN UPDATED: ☑ YES ☐ NO

SIGNATURE:	STAMP/ PRINT NAME: Valentin Bonilla, PA
DATE: 3/13/10	TIME: 0850

CHS 342 (Rev. 12/05)

(75)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name: Henry Levar   DOB: 11/2/77

FROM: AMKC, 349-07-21085
Correctional institution   Inmate no.

Referred to: Mental Health   Ward / Clinic

Hospital   / Clinic no.

Leave blank for hospital use

Chief complaint or findings: 32 y/o M c hx MH Disorder s/p multiple trauma

Diagnosis, treatment and medications by C.H.S.:
Hospital Return cleared by Elmhurst

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:
ER [illegible] denies suicidal / homicidal ideations, delusions or hallucinations. Please [illegible]

Request:

Valentin Bonilla, PA

Date 3/13/10 Referring Physician [signature] Phone [illegible] Approved

Consultation, findings and recommendations:
3/13/10
C.21 #13
Continue GP [illegible]

Date 3/13/10   Physician [signature] ACSW LCSW-R

Reminder: Fully Complete the Problem List

Copy

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Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

3/13/2010
8:59:22 AM

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	7839962Z
DOB:	11/7/1977	Site/Housing:	AMKC/QUAD-L10		
Drug:	Motrin			Dosage:	400MG
Form:	Tab	SIG:	1 tab po bid		
Reason:	Other - Anti Inflamitory	Start:	3/13/2010	Duration:	5 days
Written by:	Valentine Bonilla, PA - Physician Assistant				
Approved by:					
Allergies:	NKA			Pharm:	_____

DC:

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	7839962Z
DOB:	11/7/1977	Site/Housing:	AMKC/QUAD-L10		
Drug:	Tylenol/Codeine #3			Dosage:	300-30MG
Form:	Tab	SIG:	2 tabs po bid prn		
Reason:	Other - Pain Management S/P injury	Start:	3/13/2010	Duration:	5 days
Written by:	Valentine Bonilla, PA - Physician Assistant				
Approved by:					
Allergies:	NKA			Pharm:	_____

DC:

PROGRESS NOTE Henry, Levar 349-07-21085

EVERY ENTRY MUST BE DATED AND SIGNED

DATE	OBSERVATIONS
C95 MH 3/15/10 6:00pm	Pre Hearing Detention REVIEW Based on clinical interview and chart review. Mr. Levar Henry, a 31 year old, employed, married with five children, African American man, was incarcerated on Riker's Island on 11/16/07 for weapons sale and drug sale. He has a possible sentence of five years to life because of prior convictions. He has served a total of approximately ten years cumulative prison time during various incarcerations. He returns to court 3/9/10 whern he hopes to begin trial. He is interviewed for Pre Hearing Detention because of a fight on 3/13/10. During this ~~incarceration he has served time in both the CPSU and the MHAUH~~. Patient denies history of psychiatric treatment in the community. Mental health treatment for depression began about 2004 while incarcerated by NYS DOCS. He was given an antidepressant (perhaps Celexa). He has never been admitted for inpatient treatment. He is diagnosed: Axis I) Mood D/o, NOS. Axis II) ASPD. Axis III) None Reported. He is treated with Risperdal 1mg HS and Paxil 40mg HS. He is not classified Seriously and Persistently Mentally Ill. On interview he is cooperative with good eye contact. Speech is normal rate and volume. Mood is anxious. He is fearful of returning to segregation (especially MHAUII) because he states he has a federal law suit pending against several officers and fears retaliation by the officers. He denies current deliberate self injurious wish or plan. He states he's trying to protect himself. There is no apparent thought D/O; he denies hallucination. Insight and judgment are adequate; impulse control is adequate as well. Ms. Manneti, mental health administrator on call consulted about placement options and recommends suicide watch to reassure patient that his safety is of concern to all staff. Patient also evaluated by psychiatrist for psychiatric contraindications to placement in MHAUII and no contraindications are apparent. Patient is appropriate for placement in MHAUII on suicide watch. Thomas F. Ryan, Ph.D. Clinical Supervisor

(79)

COF ECTION DEPARTME.. CITY OF NEW YORK

PRE-HEARING DETENTION LOCK-DOWN CLEARANCE REPORT

Form: 4501B
Rev.: 10/14/05
Ref.: Dir. #4501R-A

SECTION I - TO BE COMPLETED BY TOUR COMMANDER

A) To: Mental Health Unit Chief, AMKC
Facility

B) Inmate Information:

Last Name: HENRY First Name: LEVAR Book & Case #: 3490721085M

NYSID #: 07839962Z Facility: AMKC Housing Area #: QL10

C) The above named inmate has been identified for Pre-Hearing Detention (PHD) and has been charged with violation of institutional or departmental rules:

- An I.I.S. inquiry indicated that the inmate is known to Mental Health. ☑
- The pending lockdown of the inmate into PHD is less than five (5) days of the inmate's date of admission into DOC custody ☐

Please submit a summary of your findings and recommendations regarding the inmate's placement in Lock-down status as well as for the disposition of the disciplinary hearing to the Tour Commander.

D) Prepared by: SHANNON (Print Name) _____ (Signature) CAPTAIN (Rank/Title) 1628 (Shield/ID #) 3-12-10 (Date)

SECTION II - TO BE COMPLETED BY MENTAL HEALTH STAFF

A) Based on Mental Health staff review, the inmate:

☒ Is known to Mental Health and may be placed in lock-down status in:

☐ A Punitive Segregation Unit ☒ A Mental Health Assessment Unit for Infracted Inmates (MHAUII)

☐ Is to be committed to a psychiatric hospital.

B) Recommendations to Adjudication Captain:

1. ☐ Suspend disciplinary hearing until ___/___/___ pending further evaluation of this inmate's mental status. (May not exceed seven (7) days from date of notification by DOC staff).
2. Proceed with disciplinary process, but take the following precautions:
   - ☐ If found guilty, inmate may only be housed in the Mental Health Assessment Unit for Infracted Inmates (MHAUII).
   - ☐ Other: _____
3. ☐ A representative of the Mental Health Staff wishes to attend the hearing.
4. ☐ Proceed with disciplinary process. No special precautions are required.

C) Additional Comments:

Patient needs to be on suicide watch

D) Prepared by: Thomas F. Ryan, PhD (Print Name) Clinical Supervisor _____ (Signature) 3/15/10 (Date)

Distribution:

Original: Punitive Segregation Facility
Copies: Deputy Warden for Security (Facility of occurrence)
Operations Security Intelligence Unit (OSIU)
Adjudication Captain
Inmate's Legal Folder
Mental Health Office

NYC Health

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

No Clert

Henky, Levar
3490721085

MENTAL HEALTH PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

DATE: 3-6-10 **TIME:** 9am **LOCATION:** B Brave

SUBJECTIVE: Pt. was seen by Dr. Chukwurah and writer. Pt. reported he was not suicidal and stated that he was afraid DOC was going to kill him if he went to the box. Pt. reported he had to go to court for a big case.

OBJECTIVE:

Mental Status Examination:

General Appearance: Approp'te

Mood: neutral **Affect:** Approp'te **Thought Process:** logical

Perceptions: WNL

Insight: fair **Judgement:** fair **Impulse Control:** fair

Other: **S/H thoughts:** None

S/H Plan: No **S/H intent:** No

RISK ASSESSMENT (describe both chronic and acute):

1. Risk factors:

Pt. has hx of mood disturbance. Pt. is facing jail time. Pt reports fighting w/ DOC

2. Protective factors:

Pt has no hx of self harm. Pt. is fully [illegible] but claims he doesn't need treatment

Considering the above factors, assess the current risk level: Low ✓ Moderate ____ High ____

ASSESSMENT:

Dr. Chukwurah felt that pt. was well to take off watch. Writer agreed pt. was well to take off watch

AXIS I: Mood D/O NOS **AXIS IV:** Moderate

AXIS II: ASPD **AXIS V:** 65-70

AXIS III: None

PLAN (Be sure to address acute risk factors if any):

#1 - Remove from Suicide watch

Evan Baker LMSW
Signature of Mental Health Staff

Evan Baker LMSW
Print Name of Mental Health Staff

CITY OF NEW YORK

EF. 10/1/93

RE: OPERATIONS ORDER #22/93

MENTAL HEALTH STATUS NOTIFICATION AND MENTAL OBSERVATION TRANSFER FORM

(81)

TO BE COMPLETED BY MENTAL HEALTH/CLINICAL STAFF

INMATE NAME Henry Isaac

FACILITY BBHPW

BOOK & CASE # 3490721085

NYSID # 7839962Z

DATE 3/16/10

Based on a clinical interview this date the following marked (X) indications apply:

- ☐ SUICIDAL AND / OR HIGHLY SELF-INJURIOUS
- ☐ HIGHLY ASSAULTIVE
- ☐ RECEIVING PSYCHOTROPIC MEDICATION
- ☐ DEVELOPMENTALLY DISABLED
- ☐ 730 EXAMINATION PENDING
- ☐ HISTORY OF VIOLENCE TOWARDS _____

☐ TRANSFER TO:

PSYCHIATRIC PRISON WARD: ☐ BHPW ☐ KCHPW ☐ EHPW

DOC FACILITY: ☐ C-71 MENTAL HEALTH ☐ BRONX ASSAULTIVE UNIT

OTHER M.O. HOUSING: ☐ DORMITORY ☒ CELL ☐ EITHER

SPECIAL PRECAUTIONS REQUIRED:

- ☐ ENHANCED SUICIDE OBSERVATION (ESO)
- ☐ SUICIDE WATCH
- ☐ GENERAL POPULATION – NO DANGER TO SELF OR OTHERS
- ☐ NO TRANSFER REQUIRED, BUT MOVE TO ☐ DORMITORY ☐ CELL

Remove from Suicide watch

ADDITIONAL INFORMATION / RECOMMENDATIONS:

Remove from Suicide watch

INTERVIEWER SIGNATURE [signature]

INTERVIEWER NAME (PRINT) Joan Baker LMSW

TIME OF INTERVIEW 5pm HRS.

DATE OF INTERVIEW 3/16/10

TO BE COMPLETED BY DEPARTMENT OF CORRECTION STAFF

TIME OF NOTIFICATION TO DOC: _____ HRS.	PERSON NOTIFIED (Print Name & Rank)
TIME OF NOTIFICATION TO NAMCU: _____ HRS.	PERSON NOTIFIED (Print Name & Rank) #
TRANSFER LOCATION / FACILITY	HOUSING AREA / BED / CELL
PERSON NOTIFIED AT RECEIVING LOCATION (As Required) / PRINT NAME	RANK/TITLE / SHIELD NO./ID

Form RID18 Rev 6/98

(82)

NYC Health
THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

Patient name: HENRY,LEVAR **Facility:** GRVC

Book Case: 3490721085

DATE	TRANSFER CHART REVIEW
3/16/2010	*PART ONE* NEW FACILITY: GRVC PREVIOUS FACILITY: AMKC
TIME:	INTAKE HISTORY & PHYSICAL DOCUMENTED: [☑] YES [☐] NO
11:08 PM	RPR RESULTS: [☐] POS [☑] NEG PPD RESULTS: [☐] POS [☑] NEG [☐] PENDIN
	CXR RESULTS: [☐] ABNORMAL [☐] NORMAL [☑] NOT INDICATED [☐] PENDIN
	NURSING FOLLOW-UP SCHEDULED: [☐] YES F/U DATE: [☑] NOT INDICATED
	PRIORITY REVIEW REQUIRED: [☐] YES [☑] NO
	REASONS (CHECK ALL THAT APPLY):
	[☐] PPD pos Pt with no CXR report [☐] Pt on Methadone
	[☐] HIV pos Pt with no CXR report [☐] Pt on Coumadin
	[☐] VCBC Pt on medications [☐] Pt with expired or soon to be expired medications
	[☐] Chronic condition poorly controlled OR unstable chronic dz [☐] Acute problem needing follow-up
	[☐] Transfer to Segregation [☐] OTHER:
	PRIORITY CHART GIVEN TO: (*NAME*) ☐MD, ☐DO, ☐NP, ☐PA
	COMPLETED BY: Pierce MP lpn PRINT/STAMP: 3/16/2010 11:08:03 PM
DATE	*PART TWO*
3/17/2010	CHRONIC CARE PROBLEMS AND F/U DATES AS INDICATED: [☐] NO ACTIVE PROBLEMS
TIME:	1. multiple contusions f/u prn 3. None 5. None
12:46 AM	2. depression MH f/u 4. None 6. None
	OTHER ACTIVE PROBLEMS AND F/U DATES AS INDICATED:
	1. None 3. None 5. None
	2. None 4. None 6. None
	LAB / X-RAY F/U DATE AS INDICATED: [☑] NONE
	ALLERGIES: [☐] YES: [☑] NONE
	LIST MEDS RE-WRITTEN (TRANSFERS FROM VCBC, NIC, CDU): [☑] NO MEDS
	CONSULTS RE-WRITTEN (IF PAST DUE OR NO RECORD IN CHART: [☑] NO CONSULTS
	DIETARY CONSULT WRITTEN: [☐] YES [☑] NO
	MENTAL HEALTH F/U: [☑] YES, ROUTINE CONSULT [☐] YES, STAT CONSULT [☐] NOT INDICATED
	PATIENT CALLED TO CLINIC: [☐] YES (SEE PROGRESS NOTE) [☑] NOT INDICATED
	OK FOR FOOD HANDLER'S CERTIFICATE [☐] YES [☑] NO, REASONS:
	MO
	COMPLETED BY: MADHAVA, VALSA PRINT/STAMP: 3/17/2010 12:46:55 AM

(83)

~~No chart~~

NYC Health

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Henry Levar
3440721085

DATE	OBSERVATIONS
3/16/10	Psych: NOC
CPNP	S: Patient is seen together with MHC
13B:	to re-evaluate his new for danger, as he
6:55pm	is on suicide watch (recent transfer in)
	as a precaution. He is well known to
	this writer and has no recent suicide
	attempt, gesture, or self-abusive behaviors
	He is placed in solitary confinement due to
	owing time. He reports being "OK"
	and states that he never reported thoughts,
	plan, intent to harm self in any way.
	O: He is alert, calm, cooperative, relates
	conversationally. Speech is fluent, thought
	process coherent and goal-directed.
	No psychotic features or major mood
	symptoms noted. He denies SI/HI thoughts,
	plan, intent.
	A: The patient is stable and currently does
	not seem to pose a danger to self.
	P: - Discontinue suicide watch.
	- Will continue routine MH follow up
	Suk MD

CHS 288 (Rev. 10/09)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(84)

NYC Health

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

Henry, Levar
349-07-21085

EVERY ENTRY MUST BE DATED AND SIGNED

DATE	OBSERVATIONS
3/17/10	CLINICAL SUPERVISOR M.H. NOTE:
GRVC	Chart reviewed; pt. is a recent transfer-in fm
13B	MHAUID from AMKC/C-95 showing 8 days owed
11:15 am	from previous fight & PHD for a fight 3/13/10.
	Pt. has spent time in both CPSU & MHAUID before.
	On 2/27/09 he was cleared for CPSU; on 3/15/10
	C.S. note indicated MHAUID on S.W. as a precaution
	"to reassure pt. that his safety is of concern to all
	staff" given pt's concern of retaliation by officers
	b/c of pending law suit. Pt's watch D/C'ed
	yesterday evening in MHAUID by Clinician & Psychiatrist
	as he was stable and not a threat to self or others.
	Pt. has current dx of Mood D/O NOS & ASPD
	& is prescribed Risperdal & Paxil thru 4/5.
	Pt. is assigned to Clinician & Psychiatrist
	for MH f/u. TPR due 3/30 at G.P. level of
	care, but can be completed earlier at M.D.
	level of care. Pt. out to court today, may be on
	trial at this time.
	- David Jurich
	David Jurich, PhD
	Clinical Supervisor

NYC Health

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

Henry, Leva
3490721085

MENTAL HEALTH PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

DATE: 3/18/10 TIME: 11 am LOCATION: GRVC-15B

SUBJECTIVE: Pt seen for TAR. Pt reports being beaten up by CSS [illegible] claiming for no apparent reason. Was sent to the hospital for 2 days and was sent to the Box without receiving a ticket. Pt is requesting to be cleared for MO and sent to OBCC instead stating the DOC [illegible] until he is there. Last time gave him more Box days for no reason when he applied [illegible] against this.

OBJECTIVE: Pt A+O x3, clean, good rapport

Mental Status Examination:

General Appearance: Fair

Mood: Anxious Affect: Congruent Thought Process: Goal-directed

Perceptions: Denies AVH

Insight: Impaired Judgement: Impaired Impulse Control: Fair

Other: S/H thoughts: Denies

S/H Plan: Denies S/H intent: Denies

RISK ASSESSMENT (describe both chronic and acute):

1. Risk factors: history of depression, ASPD, Box days

2. Protective factors: good coping skills, family support, goal-directed to leave [illegible]

Considering the above factors, assess the current risk level: Low ✓ Moderate ____ High ____

ASSESSMENT: Pt engaged, responsive, currently stable, goal-directed + fit for OBCC

AXIS I: Mood D/O NOS AXIS IV: Mod

AXIS II: ASPD AXIS V: 65

AXIS III: None

PLAN (Be sure to address acute risk factors if any):

Update TAR. Continue seeing pt weekly for MH

[signature]
Signature of Mental Health Staff

Joshua Rosenthal, MHC
Print Name of Mental Health Staff

CHS 288-L (01/10)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(86)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

Henry, Levar
349-07-21085, 7839962Z
11/7/1977, M

DATE	OBSERVATIONS
3/20/10	MD visit
9AM	B [illegible]
130	S O
P	I need my motrin renewed for pain
	A/P
	Pygeum, motrin
	Rx : motrin
	[signature] Jane Sanjose, MD

(87)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

3/20/2010
1:09:52 PM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**GRVC/13B**		
Drug:	**Motrin**			Dosage:	**400MG**
Form:	**Tab**	SIG:	**1 tab bid,pc**		
Reason:	**Other - renew**	Start:	**3/20/2010**	Duration:	**4 days**
Written by:	**Jane Sanjose, Physician**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC: _____

C

(88)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Levar B&C #: 34907210 85

Date: of Appointment: 3/22/10 Facility: ~~AMCC~~ GRVC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☑ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☑ No	☐ N/A
Problem list in RIIS updated:	☑ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☑ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☑ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☑ Other: 3 wks

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. x-ray R elbow
2. Handicuff in front
3.
4.
5.
6.

L Lieberman MD — Signature
Lester Lieberman, MD — Provider Stamp
3/22/10 — Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(89)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

FOR POC

Patients' Name Henry, Lovar DOB 11/7/77

FROM 6 RNC 1349072108S
Correctional institution Inmate no.

Referred to FOR POC Ward / Clinic

Hospital SA / Clinic no.

Chief complaint or findings:

1/10 Hand wt in plant for

Diagnosis, treatment and medications by C.H.S.:

Tetanus for yrs

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date 3/22/10 Referring Physician [illegible] MD Phone _____ Approved _____

Consultation, findings and recommendations:

✓

3/23/10

Date _____ Physician _____

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(90)

Follow up 3wks

CONSULTATION REQUEST MAR 23 2010

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note

Signature

Name Stamp — Date 4/30/10

8A

Patients' Name Henry, Levar DOB 11/7/77

FROM 6RVC 5490721085
Correctional institution Inmate no.

Referred to Ortho Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

Follow up 3wks for

Diagnosis, treatment and medications by C.H.S.:

Rt elbow

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Lester Lieberman, MD

Lester Lieberman, MD

Request:

Date 3/22/10 Referring Physician [signature] MD Phone ____ Approved ____

Consultation, findings and recommendations: x-ray AP + lat Rt elbow. Rt olecranon spur [illegible]. No Fx

PE: Tender Rt lateral epicondyle [illegible] Rt elbow.

Dx: Rt Lat. Epicondylitis

Rx: ~~[illegible]~~

~~[illegible]~~

① [illegible] c [illegible] 30 mg, TBID X 5 days.

② P.T.

③ ROC 6 wks.

Date 4/29/10 Physician [signature] MD

CHS 5014 (Rev 5/04)

Reminder: Fully Complete the Problem List

Lester Lieberman, MD

91

C-71

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Levar B&C #: 3490721085

Date: of Appointment: 3/23/09 Facility: AMCC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☒ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ _____ 3/23/09
Signature Provider Stamp Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Provider will complete Section C MM049 (Rev. 6/07)

(92)

NYC Health

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

Henry. Levon
J49072 1085

MENTAL HEALTH PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

DATE: 3/23/10 TIME: 10:15 AM LOCATION: GRVC-13B

SUBJECTIVE: Pt seen for MH F/U. Pt reports he went to Bellevue yesterday and they took x-rays of his elbow that is injured and told him he will have to wait 3 weeks before he gets the results, which is upsetting him, as well as the fact they did not dress or treat his elbow or even give him pain meds, which he claims he needs. Pt is hoping to be leaving the box today as he was given only [illegible] days - scheduled for his release today.

OBJECTIVE:

Pt o×3, alert, good reliable

Mental Status Examination:

General Appearance: Well groomed

Mood: Mildly Anxious Affect: Congruent Thought Process: Goal-directed

Perceptions: Denies AVH

Insight: Marginal Judgement: Marginal Impulse Control: Fair

Other: S/H thoughts: Denies

S/H Plan: Denies S/H intent: Denies

RISK ASSESSMENT (describe both chronic and acute):

1. Risk factors: History of depression, ASPD, Box days, good duration & leaves housing area

2. Protective factors: Improved coping skills, family support.

Considering the above factors, assess the current risk level: Low ✓ Moderate ____ High ____

ASSESSMENT: Pt very engaged, responsive, stable, good duration & leaves MHADE

AXIS I: Mood D/o NOS AXIS IV: Mod

AXIS II: ASPD AXIS V: 65

AXIS III: ~~[illegible]~~ Injured elbow

PLAN (Be sure to address acute risk factors if any):

Continue seeing Pt weekly for MH

[signature]
Signature of Mental Health Staff

Joshua Rosenthal, MHC
Print Name of Mental Health Staff

CHS 288-L (01/10)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

93

Prison Health Services, Inc. - Study Notes/Preliminary Report

Patient: Henry, Levar	**ID:** 07839962Z
DOB: 11/7/1977	**Accession #:** 34039
Primary Location: WEST CR	
Ordering Physician: Grvc, George R. Vierno Center	**Phone: Pager:**
Procedure: Elbow Right Ap, Lateral	**Study Date:** 3/24/2010 8:46:45 AM
Reason: N/A	

RIEPF\PARKSSP, Parks, Scott - 3/25/2010 5:50:32 PM Edit

RIGHT ELBOW: Tiny olecranon spur. F/U prn.

RIEPF\PARKSSP, Parks, Scott - 3/25/2010 5:50:09 PM Edit

STUDY: RIGHT ELBOW X-RAY CLINICAL HISTORY: TECHNIQUE: FINDINGS: There is no radiographic evidence of fracture or joint effusion. The articular spaces are maintained. There is a tiny olecranon spur. IMPRESSION: Tiny olecranon spur. Report Electronically Signed by: Jack Baldasar Report Signed on: 03/24/2010 9:28 PM

Abnormal

(94)

NYC Health

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

HENRY LEVER
349-07-21085

PROGRESS NOTE

EVERY ENTRY MUST BE DATED AND SIGNED

DATE	OBSERVATIONS
3/26/10	Sick call;
[illegible]	s/p injury / muscle pain
(8-4)	tooth ache + 5 days.
	O: not in acute distress
	Temp 98° P 78 BP 110/70
	RR 14/mt
	Cardiac: [illegible] 0
	Lungs: clear
	Abd: organomegaly 0
	CNS: No focal signs
	A/P S. muscle Trauma
	Naprosyn [illegible] [illegible]
	po BID x 4 days prn
	tooth ache – Dental Consult.
	A. Reddy, MD
	[signature]

CHS 288 (Rev. 10/09)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(95)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Devan B&C #: 349072085

Date: of Appointment: _____ Facility: Guam

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Urology
☐ Dermatology	☐ Neurology	☐ PT	☐ Mammo / Sonography
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ OB / GYN
			☐ Oral Surgery

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☐ Other:_____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature | Provider Stamp | Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(96)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

3/26/2010
11:11:59 AM

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	7839962Z
DOB:	11/7/1977	Site/Housing:	GRVC/8A		
Drug:	Tylenol/Codeine #3			Dosage:	300-30MG
Form:	Tab	SIG:	2 tab po bid prn		
Reason:	Other - pain prn	Start:	3/26/2010	Duration:	4 days
Written by:	Allareddy v.k. Reddy, Physician				
Approved by:	Allareddy v.k. Reddy, Physician			Pharm:	_____
Allergies:	NKA				

DC: _____

(97)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lavar B&C #: 349072/085

Date: of Appointment: _____ Facility: Bru

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☐ Other:_____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ Signature _____ Provider Stamp _____ Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D Provider will complete Section C

(98)

NYC Health

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

MENTAL HEALTH PROGRESS NOTE

349 0721085

EVERY ENTRY MUST BE DATED AND SIGNED

Henry, Levar

DATE: 4-27-10 **TIME:** 4PM **LOCATION:** GRVC 8A

SUBJECTIVE: Pt told clinician that it is the same "shit". Don't like GRVC due to how it is operated. Waiting to see follow up with orthopedic as promised several weeks ago, waiting to see dental. Taking medication. Reports fair appetite & sleep. Pt denied intent to harm self or others

OBJECTIVE: OX3 depressed mood c appropriate affect, coherent speech, no danger to self or others.

Mental Status Examination:

General Appearance: Fair

Mood: depressed **Affect:** appropriate **Thought Process:** no FTD

Perceptions: none

Insight: fair **Judgement:** fair **Impulse Control:** good

Other: **S/H thoughts:** none

S/H Plan: none **S/H intent:** none

RISK ASSESSMENT (describe both chronic and acute):

1. Risk factors: Depression, legal case

2. Protective factors: has young children

Considering the above factors, assess the current risk level: Low ___ Moderate ___ High ___

ASSESSMENT: Pt continues to c/o being in GRVC and failure of medical to follow up c services. Problematic mood is also stressful and chris not supportive. Currently prescribed Paxil 40mg and Risperdal [illegible]

AXIS I: Mood Do. NOS **AXIS IV:** Moderate

AXIS II: ASPD **AXIS V:** 65

AXIS III: none

PLAN (Be sure to address acute risk factors if any):

Continue in general population c MH follow up. TPR completed c pt.

[signature]
Signature of Mental Health Staff

Henry Lawrence, LCSW-R
Mental Health Professional
Print Name of Mental Health Staff

(99)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name HENRY, Levar DOB 11-7-77

FROM GRVC Correctional institution , 349072108S Inmate no.

Referred to A.n.t. Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

H requesting to see A.n.t.

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date 4-27-10 Referring Physician [signature] Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(T00)

Follow up 6 WKS

CONSULTATION REQUEST 1/n 6/10

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry, Havar DOB 11/7/77

FROM GRVC 3490721085
Correctional institution Inmate no.

Referred to Ortho Ward / ~~Clinic~~

Hospital WF / Clinic No.

Leave blank for hospital use

Consult Review
On ~~Site~~ Specialty Clinic
~~No Action Needed~~
See Progress Note

Signature

Curt Walker, RPA-C 6/11/10
Name Stamp Date

Chief complaint or findings:

Follow up 6 WKS for R elbow

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date 4/29/10 Referring Physician [signature] MD Phone Approved

Consultation, findings and recommendations: somewhat better, ROM R elbow 0 → 135° flexion, ✓ [illegible]

dx: R lat Epicondylitis
Rx: cont PT 6 WKS
RTC 8 WKS.
F/u [illegible]

Date 6/10/10 Physician [signature] MD

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List Lester Lieberman, MD

(101)

CONSULTATION REQUEST 5/4/13

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name Henry, Lamar DOB 4/7/77

FROM GRVC / 3490721085
Correctional institution / Inmate no.

Referred to P.T. Ward / Clinic

Hospital Ulf. / Clinic No.

Chief complaint or findings: Pt c Rt Lat. Epicondylitis

Diagnosis, treatment and medications by C.H.S.: Please do Moist heat ultrasound & exercises

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Lester Lieberman, MD
Lester Lieberman, MD

Request:

Date 4/29/10 Referring Physician [signature] MD Phone ______ Approved ______

Consultation, findings and recommendations: pt is a 33 y/o m c h/o no known mech of injury. woke up + was in cuffs → elmhurst - x-rays - unknown results + xrays - nkers - pt unclear as c paperwork; pt c c/c of post (R) elbow c sup/pron c arm exercises; "some kind of spur" - (PMH) Ø (PSH) Ø (Meds) Tyl #3, ibuprofen, psych w/ past (precautions) Ø ortho (Dx) (R) lat. epicondylitis

(PE/obs) (R) elbow - AROM - WFL
PROM - WFL
MMT - 4-/5 - flex/ext ↑ lat epic.

Ø edema Ø deformity Ø ecchymosis
(+) TTP (R) med/lat epicondyle + (R) lat wrist extensors

Pt. to be seen for
~~[illegible]~~ - mud (R) elbow
10 visits
- elbow stretch
- MFR - elbow

Date 5/6/10 Physician [signature] PT

Reminder: Fully Complete the Problem List

CHS 5014 (Rev. 5/04)

(102)

CONSULTATION REQUEST 5/4/13

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use
Consult Review On Island Specialty Clinic ☒ No Action Needed ☐ See Progress Note [signature] Signature Curt Walker, RPA-C Name Stamp   Date 5/7/10

Patients' Name Henry, Lamar DOB 4/7/77

FROM GRVC, 349072108 5
Correctional institution Inmate no.

Referred to P.T. Ward / Clinic

Hospital Unf. / Clinic No. ______

Chief complaint or findings:

Pt c̄ Rt Lat. Epicondylitis

Diagnosis, treatment and medications by C.H.S.: Please do Moist heat, ultrasound & exercises

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Lester Lieberman, MD
Lester Lieberman, MD

Request:

Date 4/29/10 Referring Physician [signature] MD Phone ______ Approved ______

Consultation, findings and recommendations: pt is a 33 y/o ♂ c̄ h/o no known mech of injury. woke up & was in cuffs → elmhurst – x-rays – unknown results & xrays – nkers – pt unclear as c̄ paperwork; pt c̄ c/o of pain Ⓡ elbow c̄ sup/pron c̄ arm exercises; "some kind of spur" – (PMH) ∅ (PSH) ∅ (Meds) Tyl. #3, Ibuprofen, psych in past (precautions) ∅ ortho (Dx) Ⓡ lat. epicondylitis

(Pelobs) Ⓡ elbow – AROM – WFL
PROM – WFL
MMT – 4/5 – flex/ext ↑ lat epic.

⊖ edema ⊖ deformity ⊖ ecchymosis
⊕ TTP Ⓡ med/lat epicondyle + Ⓡ lat wrist extensors

Pt. to be seen for ~~[illegible]~~ – mho Ⓡ elbow
1° lat
– elbow stretch
– MFR – elbow
[initials]

Date 5/6/10 Physician [signature] PT

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(103)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name 349 Harry Kevan DOB 11/7/77

FROM GRVC MO / 349-07-21083

Correctional institution   Inmate no.

Referred to GRVC DOC Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings: - Please

Due to Medical Reasons

Diagnosis, treatment and medications by C.H.S.:

Front cuff Mr Henry for

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

One Week

Pending ortho Evaluation.

Request: Thanks

Juan A. Medina, MD
Medical Director, GRVC

Date 4/29/10 Referring Physician [signature] Phone ______ Approved ______

Consultation, findings and recommendations:

Date ______ Physician ______

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(104)

CONSULTATION REQUEST 5/27

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Routine
4/29/10
Meade

Patients' Name Henry Ieven DOB 11/7/77

FROM Corve NY 1349-07-21085T
Correctional institution Inmate no.

Referred to Ortho Ward / Clinic

Hospital WF Bronx / Clinic No.

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note

Scott Parks, RPA-C 5/27/10
Signature
Name Stamp Date

Chief complaint or findings: - Please Evaluate Mr. Henry - Seen by RI ortho 3/22/10 - Scheduled for Rte 3 wks Thank.

Diagnosis, treatment and medications by C.H.S.

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request: Pain RT lateral Epicondyle x Ray ok -

Date 4/29/10 Referring Physician Medina Phone Juan A. Medina, MD Medical Director, GRVC Approved

Consultation, findings and recommendations: Pain Rt elbow. Lateralia. Henry P.T.
Dx: Rt lat Epicondylitis
Rx: cont PT for 6 wks
RTC 8 wks
F/u to communicated to pt.

Date 5/26/10 Physician Lester Lieberman MD

CHS 5014 (Rev. 5/04) *Reminder: Fully Complete the Problem List* Lester Lieberman MD

(105)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

4/29/2010
11:11:46 AM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**07839962Z**
DOB:	**11/7/1977**	Site/Housing:	**GRVC/8A**		
Drug:	**Tylenol/Codeine #3**			Dosage:	**300-30MG**
Form:	**Tab**	SIG:	**1 bid**		
Reason:	**Other - pain**	Start:	**4/29/2010**	Duration:	**5 days**
Written by:	**Lester Lieberman, Physician**				
Approved by:	**Lester Lieberman, Physician**			Pharm:	
Allergies:	**NKA**				

DC: [illegible] (copy)

(106)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Levar B&C #: 349072085

Date: of Appointment: 4/29/10 Facility: GMH

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☑ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☑ No	☐ N/A
Problem list in RIIS updated:	☑ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☑ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☑ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☑ 6 weeks	☐ Other:_____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. P.T.
2. Hydrocodone/acetaminophen 30 mg TPO BID x 5 days
3.
4.
6.

Signature | Lester Lieberman, MD (Provider Stamp) | 4/29/10 (Date)

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D | Provider will complete Section C | MM049 (Rev. 6/07)

(107)

NYC Health

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE
CORRECTIONAL HEALTH SERVICES

PROGRESS NOTE

Henry Leval
349072108S

EVERY ENTRY MUST BE DATED AND SIGNED

DATE	OBSERVATIONS
5/3/10	MD note - sick call
GRVC	C/O pain right elbow, asking for renewal of
12-308-7	tylenol #3.
	Requesting medicated shampoo
	O/E - alert NAD
	VS BP 120/60 P-74 R-14 T-97.9°
	Scalp - dandruff.
	General examination - unremarkable
	Right elbow - mild tenderness over
	lateral epicondyle.
	No swelling.
	ROM - full.
	Ass. / Plan - lateral epicondylitis - Patient was
	evaluated by Ortho.
	Pain medication - motrin 400mg P.O. BID
	Tylenol #3 - 2 tab. P.O BID PRN
	Ortho f/u pending Harjinder Bhatti, MD

CHS 288 (Rev. 10/09)

REMINDER: FULLY COMPLETE THE PROBLEM LIST

(108)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

5/3/2010
12:34:45 PM

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	07839962Z
DOB:	11/7/1977	Site/Housing:	GRVC/8A		
Drug:	Acetaminophen/Codeine #3			Dosage:	300-30MG
Form:	Tab	SIG:	1 tab po bid prn		
Reason:	Other - pain	Start:	5/3/2010	Duration:	3 days
Written by:	Harjinder Bhatti, Physician				
Approved by:				Pharm:	
Allergies:	NKA				

DC:

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	07839962Z
DOB:	11/7/1977	Site/Housing:	GRVC/8A		
Drug:	Motrin			Dosage:	400MG
Form:	Tab	SIG:	1 tab po bid		
Reason:	Other - pain	Start:	5/3/2010	Duration:	5 days
Written by:	Harjinder Bhatti, Physician				
Approved by:				Pharm:	
Allergies:	NKA				

DC:

Name:	Henry, Levar	Book & Case:	349-07-21085	NYSID:	07839962Z
DOB:	11/7/1977	Site/Housing:	GRVC/8A		
Drug:	Sebex			Dosage:	2-2%
Form:	Shampoo	SIG:	apply to affected scalp TIW		
Reason:	Other - dandruff	Start:	5/3/2010	Duration:	14 days
Written by:	Harjinder Bhatti, Physician				
Approved by:				Pharm:	
Allergies:	NKA				

DC:

Chart

(109)

5/18/10 f/u

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE 13B

Henry, Lear

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note

Signature

Jorge Villalobos, RPA
Name Stamp 5/18/10 Date

Patients' Name Henry, Lear DOB

FROM GRV 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

refer 7 PT 5/4/10

Jonathan August
Physical Therapy

Request:

Date 5/6/10 Referring Physician [signature] Phone ______ Approved ______

Consultation, findings and recommendations:

- mus/manual PT - (R) elbow + self
- stretch elbow sup/wrist flex/ext
- pt tol tx well / cont PT
- pt given f/u info

Date 5/17/10 Physician [signature]

Reminder: Fully Complete the Problem List

(110)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lavar B&C #: 349072185

Date: of Appointment: 5/6/10 Facility: GMC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☑ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

August
Signature

Jonathan August
Physical Therapy
Provider Stamp

5/6/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D Provider will complete Section C MM049 (Rev. 6/07)

(111)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name [illegible] DOB [illegible] 1/7/71

FROM Correctional institution Inmate no.

Referred to Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Pain

Due to Nerve Pain

Diagnosis, treatment and medications by C.H.S.:

Pain with Mr Henry

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

from 5/1/10 - 6/1/10

Henry

Request:

Date 5/1/10 Referring Physician [illegible] Phone Approved

Consultation, findings and recommendations:

Date Physician

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

CORRECTION DEPARTMENT
CITY OF NEW YORK

FORM 08/HS 02
EF. 10/1/93
RE: OPERATIONS ORDER #22/93

MENTAL HEALTH STATUS NOTIFICATION AND MENTAL OBSERVATION TRANSFER FORM

TO BE COMPLETED BY MENTAL HEALTH/CLINICAL STAFF

INMATE NAME	Henry, Levar	FACILITY	GRVC
BOOK & CASE #	3495721085	NYSID #	DATE 5 / 11 / 10

Based on a clinical interview this date the following marked (X) indications apply:

- ☐ SUICIDAL AND / OR HIGHLY SELF-INJURIOUS
- ☐ HIGHLY ASSAULTIVE
- ☐ RECEIVING PSYCHOTROPIC MEDICATION
- ☐ DEVELOPMENTALLY DISABLED
- ☐ 730 EXAMINATION PENDING
- ☐ HISTORY OF VIOLENCE TOWARDS_____

☒ TRANSFER TO: GP.

PSYCHIATRIC PRISON WARD: ☐ BHPW ☐ KCHPW ☐ EHPW

DOC FACILITY: ☐ C-71 MENTAL HEALTH ☐ BRONX ASSAULTIVE UNIT

OTHER M.O. HOUSING: ☐ DORMITORY ☐ CELL ☐ EITHER

SPECIAL PRECAUTIONS REQUIRED:

- ☐ ENHANCED SUICIDE OBSERVATION (ESO)
- ☐ SUICIDE WATCH
- ☒ GENERAL POPULATION – NO DANGER TO SELF OR OTHERS
- ☐ NO TRANSFER REQUIRED, BUT MOVE TO ☐ DORMITORY ☐ CELL

GRVC / G.P.

ADDITIONAL INFORMATION / RECOMMENDATIONS:

Pt. completed his MHAU II time and is returning to GRVC / G.P. (Clinician & Psych MH f/u

INTERVIEWER SIGNATURE: Jamie Smith — TIME OF INTERVIEW: 1300 HRS.

INTERVIEWER NAME (PRINT): David Jurick, PhD Clinical Supervisor — DATE OF INTERVIEW: 5 / 11 / 10

TO BE COMPLETED BY DEPARTMENT OF CORRECTION STAFF

TIME OF NOTIFICATION TO DOC: _____ HRS.		PERSON NOTIFIED (Print Name & Rank)	#
TRANSFER LOCATION	FACILITY	HOUSING AREA	BED / CELL
PERSON NOTIFIED AT RECEIVING LOCATION (As Required)	PRINT NAME	RANK/TITLE	SHIELD NO./ID

Form TH018 Rev. 6/98

(113)

NYC Health
THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

TREATMENT PLAN REVIEW AND DISCHARGE SERVICE NEEDS – UPDATE

TREATMENT MODALITY AND FREQUENCY OF SERVICE *(Check All That Apply and Indicate Frequency of Service)*					
MODALITY	FREQUENCY OF SERVICE				RESPONSIBLE STAFF
☒ Clinician Visits	☐ Weekly	☒ Bi-Weekly	☐ Monthly	☐ Other:	Stanley Killian, LMSW
☒ Psychiatrist Visits	☐ Weekly	☐ Bi-Weekly	☒ Monthly	☐ Other:	STAFF
☐ Group Therapy					

LEVEL OF CARE: ☒ GP ☐ MO ☐ MHC ☐ 23 HOUR LOCKDOWN ☐ INFIRMARY ☐ SUICIDE WATCH
MEDICATIONS: PAXIL

CURRENT DSM-IV DIAGNOSIS – CHANGED? ☒ YES ☐ NO IF YES, REASON :
AXIS I: DEPRESSIVE D/O NOS-5/13/2010 — UPDATE
AXIS II: DEFERRED-5/13/2010
AXIS III: NONE-5/13/2010
AXIS IV: LEGAL-5/13/2010
AXIS V: 65-5/13/2010

PSYCHOTROPIC MEDICATION FOR MENTAL HEALTH DIAGNOSIS: ☐ NO ☒ YES. ☐ Mood Stabilizers ☐ Antipsychotics ☒ Other
SPMI DESIGNATION AT LAST CTDP/TPR: ☐ YES ☒ NO
CURRENT SPMI DESIGNATION: ☐ YES ☒ NO IF CHANGED, RATIONALE:

☒ DISCHARGE PLAN PRESENT DATE OF DISCHARGE PLAN: 4 / 24 / 2009
☒ REVIEWED DISCHARGE PLAN WITH PATIENT, ACCEPTED BY PATIENT AND MEETS MENTAL HEALTH NEEDS
☐ DISCHARGE PLAN REQUIRES UPDATE, RE-OFFER DISCHARGE PLANNING

☐ DISCHARGE PLAN NOT PRESENT, RE-OFFER DISCHARGE PLANNING

PLEASE INDICATE REASONS FOR REFERRAL TO DISCHARGE PLANNING	
☐ A - No discharge plan present	
☐ B - Newly SPMI	Level of Care ☐ Out-patient ☐ Day treatment ☐ Residential treatment ☐ Civil Commitment
☐ C - Newly sentenced	
☐ D - Patient requests benefits or community referral change	
☐ E - Patient newly anticipates being homeless	Substance Abuse ☐ SA treatment
☐ F – Other	Community Support ☐ Case Management ☐ AOT
☐ G – Present Mental Health Treatment Needs	

COMMENTS FOR DISCHARGE PLANNING

RE-OFFER DISCHARGE PLANNING SERVICES:
☐ PATIENT DECLINES REFERRAL TO DISCHARGE PLANNING
☐ PATIENT ACCEPTS REFERRAL TO DISCHARGE PLANNING
☒ NO REFERRAL INDICATED

PATIENT'S STATEMENT OF INVOLVEMENT:
I have participated in the review of my treatment plan. I have discussed it with my Clinician/Psychiatrist and agree to participation in the plan.

☐ I want to add something: _____

Henry, Levar REVIEWED BY: PATIENT NAME	SIGNATURE	05/13/2010 DATE
Killian, Stanley COMPLETED BY: CLINICIAN NAME	SIGNATURE	05/13/2010 DATE
Ana Rodriguez, MD Senior Psychiatrist REVIEWED AND APPROVED BY: PSYCHIATRIST	SIGNATURE	5/12/10 DATE
David Jurich, PhD Clinical Supervisor REVIEWED AND APPROVED BY: UNIT CHIEF/CLINICAL SUPERVISOR	SIGNATURE	5/17/10 DATE

(114)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____ _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital _____ / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

CHS 5014 (Rev. 5/04) *Reminder: Fully Complete the Problem List*

(115)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lavar B&C #: 349072085

Date: of Appointment: 5/17/10 Facility: Gmw

(B) SPECIALTY CLINIC:

			☐ Oral Surgery
☐ Audiology	☐ GI	☐ Optometry	☐ Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Urology
☐ Dermatology	☐ Neurology	☑ PT	☐ Mammo / Sonography
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☑ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature	Provider Stamp	Date
	Jonathan August Physical Therapy	5/17/10

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D

(116)

5/24/10 FW

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name Henry, Lavar DOB

FROM GRVC, 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☑ No Action Needed
☐ See Progress Note

Signature

Jorge Villalobos, RPA 5/25/10
Name Stamp Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Jonathan August
Physical Therapy

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

refer to PT 5/24/10

Request:

Date 5/17/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

MMS/MAN PT. (R) elbow - MAN to 60 pt tolerance
+ (R) UE arm pull
- pt tol well, c/o
- pt given exs

Date 5/24/10 Physician [signature]

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(117)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lavar B&C #: 349072085

Date: of Appointment: 5/24/10 Facility: Chuuk

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☑ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☑ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

August
Signature

Jonathan August
Physical Therapy
Provider Stamp

5/24/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D

Provider will complete Section C

MM049 (Rev. 6/07)

(118)

MAY 25 2010

6/1/10 FW

CONSULTATION REQUEST

Leave blank for hospital use

Consult Review
~~On Island Specialty Clinic~~
☐ No Action Needed
☐ See Progress Note
Signature
Curt Walker, RPA-C
Name Stamp
Date 6/2/10

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry, Laure DOB

FROM GRVC , 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

Date 5/24/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- MPL/MAN PT (R) elbow
- (R) UE arm pull
- PT 70% to well... PT
- PT given f/u note

Date 6/1/10 Physician [signature]

Reminder: Fully Complete the Problem List

(19)

NYC Health
THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

TREATMENT PLAN REVIEW AND DISCHARGE SERVICE NEEDS – UPDATE

TREATMENT MODALITY AND FREQUENCY OF SERVICE *(Check All That Apply and Indicate Frequency of Service)*					
MODALITY	FREQUENCY OF SERVICE				RESPONSIBLE STAFF
☒ Clinician Visits	☐ Weekly	☐ Bi-Weekly	☒ Monthly	☐ Other:	H.Lawrence LCSW-R
☒ Psychiatrist Visits	☐ Weekly	☐ Bi-Weekly	☒ Monthly	☐ Other:	Staff Psychiatrist
☐ Group Therapy					

LEVEL OF CARE: ☒ GP ☐ MO ☐ MHC ☐ 23 HOUR LOCKDOWN ☐ INFIRMARY ☐ SUICIDE WATCH
MEDICATIONS: Paxil 40mg hs

CURRENT DSM-IV DIAGNOSIS – CHANGED? ☐ YES ☒ NO IF YES, REASON :
AXIS I: DEPRESSIVE D/O NOS-5/13/2010
AXIS II: DEFERRED-5/13/2010
AXIS III: NONE-5/13/2010
AXIS IV: LEGAL-5/13/2010
AXIS V: 65-5/13/2010

PSYCHOTROPIC MEDICATION FOR MENTAL HEALTH DIAGNOSIS: ☐ NO ☒ YES: ☐ Mood Stabilizers ☐ Antipsychotics ☒ Other
SPMI DESIGNATION AT LAST CTDP/TPR: ☐ YES ☒ NO
CURRENT SPMI DESIGNATION: ☐ YES ☒ NO IF CHANGED, RATIONALE:

☒ **DISCHARGE PLAN PRESENT** DATE OF DISCHARGE PLAN: 4 / 24 / 2009
☒ REVIEWED DISCHARGE PLAN WITH PATIENT, ACCEPTED BY PATIENT AND MEETS MENTAL HEALTH NEEDS
☐ DISCHARGE PLAN REQUIRES UPDATE, RE-OFFER DISCHARGE PLANNING

☐ **DISCHARGE PLAN NOT PRESENT, RE-OFFER DISCHARGE PLANNING**

PLEASE INDICATE REASONS FOR REFERRAL TO DISCHARGE PLANNING	
☐ A - No discharge plan present	
☐ B - Newly SPMI	Level of Care ☐ Out-patient ☐ Day treatment ☐ Residential treatment ☐ Civil Commitment
☐ C - Newly sentenced	
☐ D - Patient requests benefits or community referral change	
☐ E - Patient newly anticipates being homeless	
☐ F – Other	Substance Abuse ☐ SA treatment
☐ G – Present Mental Health Treatment Needs	Community Support ☐ Case Management ☐ AOT

COMMENTS FOR DISCHARGE PLANNING

RE-OFFER DISCHARGE PLANNING SERVICES:
☐ PATIENT DECLINES REFERRAL TO DISCHARGE PLANNING
☐ PATIENT ACCEPTS REFERRAL TO DISCHARGE PLANNING
☒ NO REFERRAL INDICATED

PATIENT'S STATEMENT OF INVOLVEMENT:
I have participated in the review of my treatment plan. I have discussed it with my Clinician/Psychiatrist and agree to participation in the plan.

☐ I want to add something:

Henry, Levar REVIEWED BY: PATIENT NAME	X SIGNATURE	05/25/2010 DATE
Lawrence, Henry COMPLETED BY: CLINICIAN NAME	SIGNATURE	05/25/2010 DATE
Ana Rodriguez, MD Senior Psychiatrist REVIEWED AND APPROVED BY: PSYCHIATRIST	SIGNATURE	5/27/10 DATE
David Jurich, PhD Clinical Supervisor REVIEWED AND APPROVED BY: CLINICAL SUPERVISOR	SIGNATURE	5/26/10 DATE

120

Follow up 8 wks.

CONSULTATION REQUEST f/u 7/24

Leave blank for hospital use

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name Henley, Levar DOB 11/7/77

FROM GRVC , 3490721085
Correctional institution / Inmate no.

Referred to ortho Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

Follow up 8 wks for Rt elbow

Diagnosis, treatment and medications by C.H.S.:

Lester Lieberman, MD

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Lester Lieberman, MD

Request:

Date 5/26/10 Referring Physician [signature] MD Phone ______ Approved ______

Consultation, findings and recommendations: Better. ROM Rt elbow intact.
⊘ tenderness Rt Lat. Epicondyle.
Dx: Rt Lat Epicondylitis
Rx: cont PT for 8 wks
follow up 8 wks
f/u w/o communicated Dept

Date 7/26/10 Physician [signature] MD

Reminder: Fully Complete the Problem List Lester Lieberman MD

(121)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

5/27/10

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

Reminder: Fully Complete the Problem List

(122)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Levar B&C #: 349072108S

Date: of Appointment: 5/26/10 Facility: GWC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☑ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☑ No	☐ N/A
Problem list in RIIS updated:	☑ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☑ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☑ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☑ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. Cont P.T 4. _____
2. _____ 5. _____
3. _____ 6. _____

L Lieberman MD Lester Lieberman, MD 5/26/10

Signature Provider Stamp Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D Provider will complete Section C MM040 (Rev. 6/07)

123

6/8/10 FU

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name Henry Inmr DOB

FROM GRVR Correctional institution , 319-078-1 Inmate no.

Referred to F Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

refer for 6/8/10

Date 6/1/10 Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

Reminder: Fully Complete the Problem List

(124)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Tavar B&C #: 34907218

Date: of Appointment: 6/1/10 Facility: Guam

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☒ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Jonathan August

Signature

Jonathan August
Physical Therapy
Provider Stamp

6/1/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D Provider will complete Section C MM049 (Rev. 6/07)

(125)

6/8/10 FW

JUN - 2 2010

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry, Lamar DOB

FROM Grvc , 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☐ No Action Needed
☑ See Progress Note

Signature

Curt Walker, RPA-C 6/9/10
Name Stamp Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer to PT 6/8/10

Request:

Date 6/1/10 Referring Physician August PT Phone Approved

Consultation, findings and recommendations:

- MWT MANAT (R) elbow
- (R) UE Arm pull
- pt told to well raise
- pt given f/w nk

Date 6/8/10 Physician August PT

Reminder: Fully Complete the Problem List

(126)

6/15/10 FW

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

RECEIVED JUN 2010

Leave blank for hospital use

6/15/10 PRW

Patients' Name Henry, Lamar DOB

FROM GRV 349 072-1085

Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer to PT 6/15/10

Request:

Date 6/8/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- MWP/MAN P.T. Ⓡ elbow
- Ⓡ UE arm pull
- pt tol tx well; cont PT
- pt given f/u w/PT

Date 6/22/10 Physician [signature]

(PE)

127

ATION REQUEST

NY DEPARTMENT OF HEALTH
AN YGIENE

RECEIVED
JUN 9 2010

Patie Henry, Lamar DOB
FRO GRV 349-072-1085
ctional institution Inmate no.
Referr PT Ward / Clinic
Hospit WF / Clinic no.

Leave blank
Consult
On Island Spe
☐ No Actio
☑ See Prog
Signatu
Curt Walker, RPA-C
Name Stamp
6/15 11 OPW

Chief Co or findings:

Diagnos treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy
6/15

Request:

Date 6/8/10 Referring Physician [signature] Phone

Consultation, findings and recommendations:

- MMP/MAN PT. Ⓡ elbow
- Ⓡ UE ampul
- pt tol tx well cont po
- pt given f/u w/o

Date 6/20/10 Physician [signature]

Reminder: Fully Co...

(128)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 3490721085

Date: of Appointment: 6/8/16 Facility: GRUC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☑ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other: 1

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature | Jonathan August Physical Therapy (Provider Stamp) | 6/8/16 (Date)

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(129)

RECEIVED

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name Hendry Levar DOB 11/7/77

FROM 6RVC. 349072108S
Correctional institution Inmate no.

Referred to Ortho Ward / Clinic

Hospital WE / Clinic no.

Chief complaint or findings:

Follow up 6 WKS.

Diagnosis, treatment and medications by C.H.S.: for Freiburg

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Lester Lieberman, MD

Lester Lieberman, MD

Request:

Date 6/16/10 Referring Physician [signature] Phone _____ Approved _____

Consultation, findings and recommendations:

Seen

Date _____ Physician _____

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(130)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lavar B&C #: 349022085

Date: of Appointment: 6/10/10 Facility: GMC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☑ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks	☑ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Medication order(s) written:	☐ Yes	☑ No	☐ N/A
Problem list in RIIS updated:	☑ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☑ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☑ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. cont PT 6wks
2. _____
3. _____
4. _____
5. _____
6. _____

Signature: [signature] Provider Stamp: Lester Lieberman, MD Date: 6/10/10

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(131)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: B49072185

Date: of Appointment: 6/15/10 Facility: GRVC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☑ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☑ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☑ Other: ____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ Signature

Jonathan August
Physical Therapy
Provider Stamp

6/15/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Provider will complete Section C MM049 (Rev. 6/07)

(132)

6/29/10 FW

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name Henry, Lamar DOB _____

FROM GRVC Correctional Institution , 349-07-1085 Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note

Signature

Curt Walker, RPA-C 6.30.10
Name Stamp Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer to PT 6/29/10

Request:

Date 6/29/10 Referring Physician [signature] Phone _____ Approved _____

Consultation, findings and recommendations:

- Mvt/mm PT (R) elbow
- (R) UE AMPROM
- PT to w/ well cont PO
- PT Given findings

Date 6/29/10 Physician [signature]

(RB)

Reminder: Fully Complete the Problem List

(133)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Ismar B&C #: 345072065

Date: of Appointment: 6/22/10 Facility: GRMC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☑ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature: Jonathan August

Jonathan August
Physical Therapy
Provider Stamp

6/22/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D — Provider will complete Section C — MM049 (Rev. 6/07)

(134)

FW 6 7/6/10

CONSULTATION REQUEST

JUN 30 2010

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name Henry, Lamar DOB

FROM GRVC 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note

Signature

Scott Parks, RPA-C 7/7/10
Name Stamp Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy
7/6/10

Request:

Date 6/29/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- MMP/MAN PT. [illegible] ® elbow
- pt tol tx well [illegible]
- pt given [illegible]

Date 7/6/10 Physician [signature]

Reminder: Fully Complete the Problem List

135

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 34907210525

Date: of Appointment: 6/29/10 Facility: GNL

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☑ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☑ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature	Jonathan August Physical Therapy	6/29/10
	Provider Stamp	Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D — Provider will complete Section C — MM049 (Rev. 6/07)

(136)

JUL 7 2010

7/13/10 FW

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name Henry, Lamar DOB

FROM GRVC 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note

Signature 7/14/10

CURT WALKER PA
Name Stamp Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Jonathan August
Physical Therapy

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

refer 2 PT 7/13/10

Request:

Date 7/6/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- Mustman PT. Therapy (R) elbow
- pt told to well [illegible]
- pt Given f/u note

Date 7/13/10 Physician [signature]

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

137

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 349072085

Date: of Appointment: 7/6/10 Facility: GMR

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☑ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☒ Other: 1

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

J Augusto — Signature
Jonathan August Physical Therapy — Provider Stamp
7/6/10 — Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Provider will complete Section C

138

FW 7/20/10

'CONSULTATION REQUEST JUL 13 2010

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name HENRY, LAVAR DOB

FROM GRVC 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Jonathan August
Physical Therapy

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

refer to PT 7/20/10

Request:

Date 7/13/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- mob/manip/therex (R) elbow
- pt tol tx well; cont PT
- pt given fu nto

Date 7/20/10 Physician [signature]

(139)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 349072185

Date: of Appointment: 7/13/10 Facility: GRH

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature	Provider Stamp	Date
August	Jonathan August Physical Therapy	7/13/10

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D Provider will complete Section C

(140)

FW

7/22/10 FW

CONSULTATION REQUEST

RECEIVED JUL 21 2010

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note
Signature
CURT WALKER, RPA-C
Name Stamp
Date 7-28-10

Patients' Name Henry, Laur DOB

FROM GRVC Correctional institution 349-072-1085 Inmate no.

Referred to PT Ward / Clinic

Hospital 8A WF / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer to PT 7/22/10

Request:

Date 7/20/10 Referring Physician J August PT Phone Approved

Consultation, findings and recommendations:

- mhp/manual PT [illegible] elbow
- pt. [illegible] wel [illegible] cont PT
- pt given [illegible]

Date 7/27/10 Physician J August PT

Reminder: Fully Complete the Problem List

(141)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lenar B&C #: 3490721085

Date: of Appointment: _____ Facility: GNR

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☐ Other:_____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ Signature _____ Provider Stamp _____ Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D **Provider will complete Section C** **MM049 (Rev. 6/07)**

(142)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

7/19/2010
1:13:06 PM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**07839962Z**
DOB:	**11/7/1977**	Site/Housing:	**GRVC/8A**		
Drug:	**Paxil**			Dosage:	**40MG**
Form:	**Tab**	SIG:	**po qam**		
Reason:	**Mental Health - depression/ bridge**	Start:	**7/19/2010**	Duration:	**5 days**
Written by:	**Zahida Azam, Psychiatrist**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC:

143

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Jewar B&C #: 34907210851

Date: of Appointment: _____ Facility: Guam

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☑ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ Signature _____ Provider Stamp _____ Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Provider will complete Section C

(144)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____ / _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital _____ / Clinic no.

Chief complaint or findings:

~~Diagnosis, treatment and medications by C.H.S.:~~

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

Reminder: Fully Complete the Problem List

(145)

follow up 8wks.

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name Henry, Levar. DOB 11/7/77

FROM GRVC. , 349072108S
Correctional institution Inmate no.

Referred to ortho Ward (Clinic)

Hospital WF / Clinic no.

Chief complaint or findings:

Follow up 8wks for
Rt Cat. Fracture 4th.

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Lester Lieberman, MD

Lester Lieberman, MD

Request:

Date 7/26/10 Referring Physician [signature] Phone _____ Approved _____

Consultation, findings and recommendations:

D/C 9/23/10 XSP

Date _____ Physician _____

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(146)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lester B&C #: 34[illegible]85

Date: of Appointment: 7/26/10 Facility: Other

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☑ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☑ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☑ No	☐ N/A
Problem list in RIIS updated:	☑ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☑ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☑ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☑ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☐ Other:_____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. P.T. 4. _____
2. _____ 5. _____
3. _____ 6. _____

L Lieberman MD Lester Lieberman, MD 7/26/10

Signature Provider Stamp Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(147)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lavar B&C #3490724085

Date: of Appointment: 7/27/10 Facility: _____

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☐ Other: _____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

_____ Signature

Jonathan August
Physical Therapy
Provider Stamp

7/27/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D Provider will complete Section C MM049 (Rev. 6/07)

(148)

8/3/10 FW

RECEIVED
JUL 28 2010

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name Henry, Lamar DOB

FROM GRVC (Correctional institution) 349-07J-1085 (Inmate no.)

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Consult Review
Leave blank for hospital use
On Island Specialty Clinic

☒ No Action Needed

☐ See Progress Note

Signature

Scott Parks, RPA-C 8/4/10
Name Stamp Date

8/3/10 FW

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer to PT 8/3/10

Request:

Date 7/27/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- MWF/MWF PO/Thera Ⓟ elbow
- PT. for wellness exam PO
- PT Give FW nuts

Date 8/3/10 Physician [signature]

R3

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(149)

Report ID: IRC00100

Pharmacy Order

Sorted by: Start Date

8/1/2009
12:10:46 PM

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**GRVC/13B**		
Drug:	**Sebulex**			Dosage:	**2-2%**
Form:	**Shampoo**	SIG:	**shamoo scalp biw**		
Reason:	**Other - seb**	Start:	**8/1/2009**	Duration:	**30 days**
Written by:	**Jane Sanjose, Physician**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC:

Name:	**Henry, Levar**	Book & Case:	**349-07-21085**	NYSID:	**7839962Z**
DOB:	**11/7/1977**	Site/Housing:	**GRVC/13B**		
Drug:	**Micatin**			Dosage:	**2%**
Form:	**Cream**	SIG:	**top to feet bid**		
Reason:	**Other - tinea p**	Start:	**8/1/2009**	Duration:	**30 days**
Written by:	**Jane Sanjose, Physician**				
Approved by:				Pharm:	_____
Allergies:	**NKA**				

DC:

C

(150)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 3457218[illegible]

Date: of Appointment: 8/3/10 Facility: GMH

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☒ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☒ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☒ Other:)

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Augusto
Signature

Jonathan August
Physical Therapy
Provider Stamp

8/3/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING
YELLOW COPY TO [illegible]

Scheduler will complete S[illegible]

(151)

8/10/10 FW

CONSULTATION REQUEST AUG - 4 2010

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry, Lucas DOB

FROM GRVC, 349-072-1085
Correctional institution — Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☐ No Action Needed
☐ See Progress Note

Signature

CURT WALKER, RPA-C 8-11-10
Name Stamp — Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

refer to PT 8/10/10

Request:

Jonathan August
Physical Therapy

Date 8/3/10 Referring Physician [signature] Phone ______ Approved ______

Consultation, findings and recommendations:

- MWD/MAN PT (R) elbow - AMPULL/MTR
- PC Tol Tx well; cont tx
- Pt given f/u info

Date 8/10/10 Physician [signature]

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(152)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lavar B&C #: 349072085

Date: of Appointment: 8/10/10 Facility: GMC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Urology
☐ Dermatology	☐ Neurology	☑ PT	☐ Mammo / Sonography
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ OB / GYN
			☐ Oral Surgery

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature	Jonathan August Physical Therapy Provider Stamp	8/10/10 Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D Provider will complete Section C MM049 (Rev. 6/07)

(153)

AUG 1 1 2010

FW 8/12/10

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry, Lamar DOB

FROM GRVC / 349-072-1085
Correctional institution / Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☑ No Action Needed
☐ See Progress Note

[signature]
Signature

Scott Parks, RPA-C 8/18/10
Name Stamp Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer to PT 8/12/10

Request:

Date 8/10/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- MWP/MANIP Ⓡ elbow - arm pull mod
- pt tol to well to tx
- pt Given F/U info

Date 8/12/10 Physician [signature]

(RE)

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(154)

NYC Health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

DIVISION OF HEALTH CARE ACCESS AND IMPROVEMENT
CORRECTIONAL HEALTH SERVICES

Patient name: HENRY,LEVAR **Facility:** GRVC

Book Case: 3490721085

DATE	TRANSFER CHART REVIEW
8/21/2010	*PART ONE* NEW FACILITY: GRVC PREVIOUS FACILITY: GMDC
TIME:	INTAKE HISTORY & PHYSICAL DOCUMENTED: [☑] YES [☐] NO
9:35 AM	RPR RESULTS: [☐] POS [☑] NEG PPD RESULTS: [☐] POS [☑] NEG [☐] PENDIN
	CXR RESULTS: [☐] ABNORMAL [☐] NORMAL [☑] NOT INDICATED [☐] PENDIN
	NURSING FOLLOW-UP SCHEDULED: [☐] YES F/U DATE: [☑] NOT INDICATED
	PRIORITY REVIEW REQUIRED: [☑] YES [☐] NO
	REASONS (CHECK ALL THAT APPLY):
	[☐] PPD pos Pt with no CXR report [☐] Pt on Methadone
	[☐] HIV pos Pt with no CXR report [☐] Pt on Coumadin
	[☐] VCBC Pt on medications [☐] Pt with expired or soon to be expired medications
	[☐] Chronic condition poorly controlled OR unstable chronic dz [☐] Acute problem needing follow-up
	[☐] Transfer to Segregation [☑] OTHER: mental health
	PRIORITY CHART GIVEN TO: (*NAME*)SANJOSE, JANE ☑MD, ☐DO, ☐NP, ☐PA
	COMPLETED BY: SANJOSE, JANE PRINT/STAMP: 8/21/2010 9:35:18 AM
DATE	*PART TWO*
8/21/2010	CHRONIC CARE PROBLEMS AND F/U DATES AS INDICATED: [☐] NO ACTIVE PROBLEMS
TIME:	1. needs annual physical 3. None DEPRESSION 5. None
9:37 AM	2. hx rt elbow epicondilytis,pt 4. None 6. None
	OTHER ACTIVE PROBLEMS AND F/U DATES AS INDICATED:
	1. None 3. None 5. None
	2. None 4. None 6. None
	LAB / X-RAY F/U DATE AS INDICATED: [☑] NONE
	ALLERGIES: [☐] YES: [☑] NONE
	LIST MEDS RE-WRITTEN (TRANSFERS FROM VCBC, NIC, CDU): [☑] NO MEDS
	CONSULTS RE-WRITTEN (IF PAST DUE OR NO RECORD IN CHART: [☑] NO CONSULTS
	DIETARY CONSULT WRITTEN: [☐] YES [☑] NO
	MENTAL HEALTH F/U: [☑] YES, ROUTINE CONSULT [☐] YES, STAT CONSULT [☐] NOT INDICATED
	PATIENT CALLED TO CLINIC: [☐] YES (SEE PROGRESS NOTE) [☑] NOT INDICATED
	OK FOR FOOD HANDLER'S CERTIFICATE [☑] YES [☐] NO, REASONS:
	COMPLETED BY: SANJOSE, JANE PRINT/STAMP: 8/21/2010 9:37:00 AM

(155)

Fw 8/24/10

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry, Omar DOB

FROM GSVC GA, 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer to PT 8/24/10

Request:

Date 8/17/10 Referring Physician [signature] PT Phone Approved

Consultation, findings and recommendations:

MWD/MAN P.T. - needs PT. (R) elbow / triceps
tears pull (R) UE

PT Tol. Tx well: cont PT
- PT Given f/u to

Date 8/24/10 Physician [signature] PT

S 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List

(156)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 349072105

Date: of Appointment: 8/17/10 Facility: GMC

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Urology
☐ Dermatology	☐ Neurology	☑ PT	☐ Mammo / Sonography
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ OB / GYN
			☐ Oral Surgery

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature	Jonathan August Physical Therapy	8/17/10
	Provider Stamp	Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D **Provider will complete Section C** MM049 (Rev. 6/07)

(157)

FW 8/31/10

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Patients' Name Henry, Lamar DOB

FROM GRVC 8A , 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☑ No Action Needed
☐ See Progress Note

Signature

CURT WALKER, RPA-C 9/1/10

Name Stamp Date

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Jonathan August
Physical Therapy

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

refer 7090 8/31/10

Request:

Date 8/24/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

= MMP ® elbow
MAN P.S. trigger pt [illegible] ® [illegible]
- pt tol. tx well [illegible]
- pt given [illegible]

Date 8/31/10 Physician [signature]

Reminder: Fully Complete the Problem List

(158)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Hanley First Name: Lamar B&C #: 349224055

Date: of Appointment: 8/31/10 Facility: GMR

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Urology
☐ Dermatology	☐ Neurology	☒ PT	☐ Mammo / Sonography
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ OB / GYN
			☐ Oral Surgery

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Follow-up Appt. within

☐ 2 weeks ☐ 8 weeks
☐ 4 weeks ☐ 12 weeks
☐ 6 weeks ☒ Other ____

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature | Jonathan August Physical Therapy (Provider Stamp) | 8/31/10 (Date)

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(59)

Pu
9/2/10

RECEIVED SEP 1 2010

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Leave blank for hospital use

Consult Review
On Island Specialty Clinic
☒ No Action Needed
☐ See Progress Note

Signature
CURT WALKER, RPA-C
9/8/10
Name Stamp Date

Patients' Name Henry, Lamar DOB

FROM GRVC , 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

~~Diagnosis, treatment and medications by C.H.S.:~~

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer 2 PT 9/2/10

Request:

Date 8/31/10 Referring Physician [signature] Phone Approved

Consultation, findings and recommendations:

- MMT (R) elbow
- trigger pt. (R) triceps
- Pt. told to wells capres
- Pt. given shots

Date 9/2/10 Physician [signature]

CHS 5014 (Rev. 5/04) *Reminder: Fully Complete the Problem List*

(60)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 34607210 85

Date: of Appointment: 9/7/10 Facility: GRV

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☒ PT	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☒ Seen need follow-up appt)
☐ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other: 1

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature

Jonathan August
Physical Therapy
Provider Stamp

9/7/10
Date

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

WHITE COPY TO *FACILITY MEDICAL RECORDS DEPARTMENT FOR FILING*
YELLOW COPY TO *UM DEPARTMENT*

(16)

ON – ISLAND SPECIALTY CLINIC

(A) PATIENT INFORMATION:

Last Name: Henry First Name: Lamar B&C #: 349072085

Date: of Appointment: 9/14/10 Facility: Guam

(B) SPECIALTY CLINIC:

☐ Audiology	☐ GI	☐ Optometry	☐ Oral Surgery
☐ Cardiology	☐ Hand	☐ Orthopedic	☐ Surgery
☐ Dermatology	☐ Neurology	☐ ~~PT~~	☐ Urology
☐ ENT	☐ Ophthalmology	☐ Podiatry	☐ Mammo / Sonography
			☐ OB / GYN

(C) PROVIDER INFORMATION:

☐ Seen (no follow-up appt needed)
☐ Seen need follow-up appt)
☒ No show (need new appt)
☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Medication order(s) written:	☐ Yes	☐ No	☐ N/A
Problem list in RIIS updated:	☐ Yes	☐ No	☐ N/A
F/u appt. updated in RIIS:	☐ Yes	☐ No	☐ N/A
Specialty Recommendation(s):	☐ Yes	☐ No	☐ N/A

Follow-up Appt. within

☐ 2 weeks	☐ 8 weeks
☐ 4 weeks	☐ 12 weeks
☐ 6 weeks	☒ Other: ____

Special Recommendations(s): (List each treatment i.e. dressing change, lab tests, x-rays needed, referral to another on/off-island clinic, equipment, etc.)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Signature: Jonathan August — Provider Stamp: Jonathan August Physical Therapy — Date: 9/14/10

(D) FOR SCHEDULING DEPARTMENT USE ONLY:

New appointment date: _____ ☐ 2ND No show (Refer Consult to SMD for re-evaluation)

Schedular / Coordinator Name: _____ Date: _____

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YELLOW COPY TO *UM DEPARTMENT*

Scheduler will complete Sections A, B, and D — Provider will complete Section C — MM049 (Rev. 6/07)

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____ _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital _____ / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

Reminder: Fully Complete the Problem List

CHS 5014 (Rev. 5/04)

SEP 8 2010

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fu 9/14/10

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

9/14/10 PM Transferred

Patients' Name Henry, LAMAR DOB _____

FROM GRVC 6A , 349-072-1085
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital WF / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Jonathan August
Physical Therapy

refer 7 days 9/14/10

Request:

Date 9/7/10 Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Disch 9/23/10 x 5 pt

Date _____ Physician _____

CHS 5014 (Rev. 5/04)

Reminder: Fully Complete the Problem List